Alberta Health Services

Alberta Health Services *Annual Report*

2012-2013

For more information about our programs and services, please visit
www.albertahealthservices.ca
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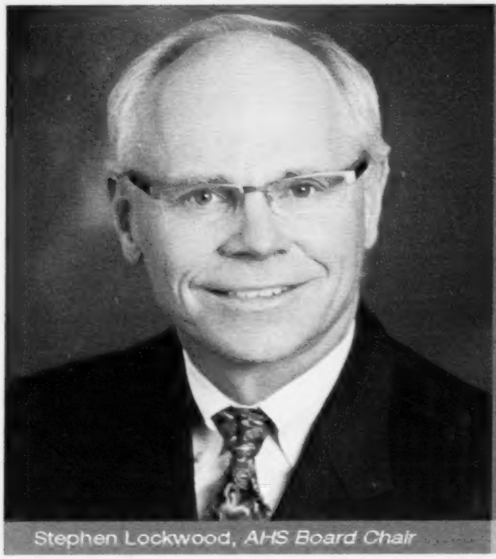


Stephen Lockwood, *AHS Board Chair*

> *"We will move forward unwavering in our commitment to build the sustainable, patient-focused and responsive health system Albertans want."*

Letter of Accountability

We are pleased to present the annual report for Alberta Health Services for the fiscal year ended March 31, 2013.

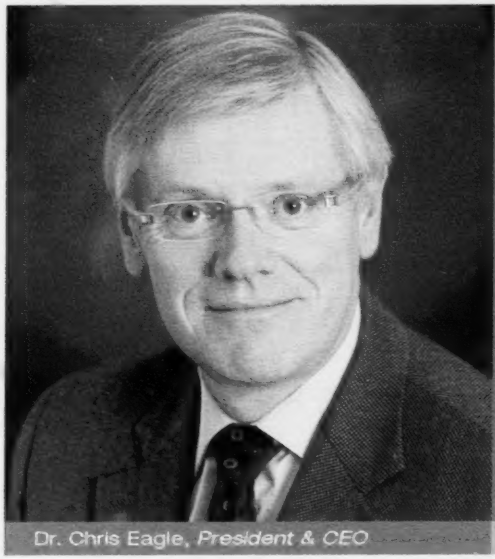
Since our inception as a provincial health delivery system, Alberta Health Services has met every challenge head on. The 2012-13 fiscal year was no exception. We concentrated on fostering a culture of safe, compassionate and quality health care, and continued to drive down decision-making closest to where care is provided to better meet the needs of Albertans. The efforts we have made this year are part of our overall plan to improve the health and wellness of the people of this province – this is, unequivocally, our first and highest priority. Building on what was accomplished over the past year, we will move forward unwavering in our commitment to build the sustainable, patient-focused and responsive health system Albertans want.

This annual report was prepared under the Board's direction, in accordance with the Government Accountability Act, Regional Health Authorities Act and instructions as provided by Alberta Health. All material economic and fiscal implications known as of June 6, 2013, have been considered in preparing the Annual Report.

Respectfully submitted on behalf of Alberta Health Services Board,

"Original Signed by Stephen Lockwood"

Stephen Lockwood
AHS Board Chair



Dr. Chris Eagle, *President & CEO*

"Our reason for being is to take care of people"

Welcome to the 2012-2013 Annual Report

The history of Alberta Health Services (AHS) is one of resilience and determination. The past year marked another milestone of progress and improvement, thanks to the commitment and compassion of the over 104,000 men and women who serve in our health system. Each and every day, they do great work caring for Albertans in a rapidly changing and always challenging environment.

During the last 12 months, we have laid the groundwork for growth and transformation, intensifying our efforts in building a progressive, patient-focused and sustainable health system. Wait times for many surgeries are down. There are more continuing care spaces for seniors and adults with disabilities. We have greater access to home care for seniors.

That isn't the whole story. Throughout Alberta, our health care providers, physicians, volunteers, foundations, community partners and, of course, our patients and their families, are a constant source of inspiration. Throughout this report, you'll read stories that illustrate the accomplishments and achievements of the past year - stories about junior high students sharing music to help dementia patients in Grande Prairie, technology that is giving Albertans the facts on cancer and how residents in our long-term care centres throughout the province helped us add some of their favourite meals to our menus. These are just a few of the stories about the people who have been helped by new AHS programs, services and innovations this year.

Providing high-quality, sustainable health care is a challenge. It is a challenge everyone at Alberta Health Services takes seriously with the health, wellness and care of our patients as their highest priority. Our reason for being is to take care of people, and year-over-year, we continue to improve the quality of health services we deliver for the 3.9 million Albertans who rely on us.

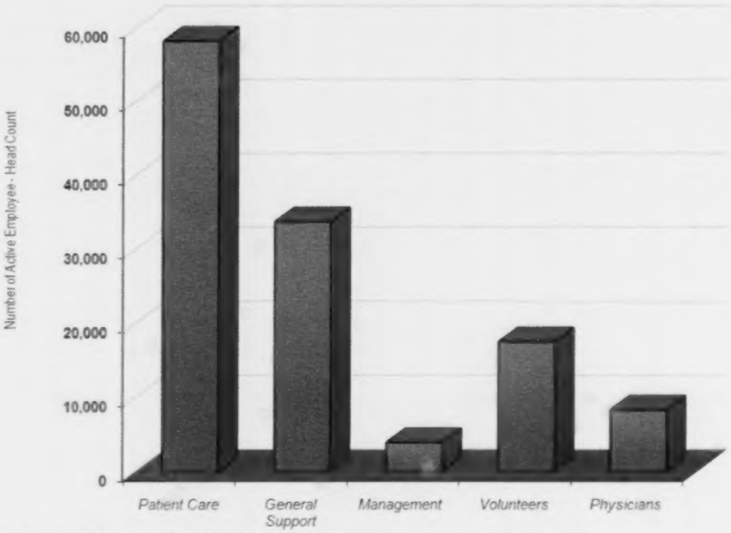
"Original Signed by Dr. Chris Eagle"

Dr. Chris Eagle
President & CEO

Who We Are

We are skilled and dedicated health professionals, support staff, volunteers and physicians who promote wellness and provide health care everyday to approximately 3.9 million adults and children living in Alberta, as well as to many residents of southwestern Saskatchewan, southeastern British Columbia and the Northwest Territories. Alberta Health Services (AHS) has over 104,000 employees, including approximately 96,100 direct AHS employees and almost 8,000 staff working in AHS wholly-owned subsidiaries such as Carewest, CapitalCare Group and Calgary Laboratory Services (excluding Covenant Health staff), 17,600 volunteers and almost 8,400 physicians (total physician count for Alberta both employed and independent physicians). Students from Alberta's universities and colleges, as well as from universities and colleges outside of Alberta, receive clinical education in AHS facilities.

Workforce as of March 31, 2013
Excluding Wholly-Owned Subsidiaries Staff



NOTE: Patient Care is nursing, professional, technical and EMS
General Support includes AUPE staff (approx. 25,700) and non-management out of scope staff (approx. 8,000).

We offer health care programs and services at over 450 facilities across the province including hospitals, clinics, continuing care facilities, mental health facilities and community health sites. This province also has an extensive network of community-based services designed to assist Albertans maintain and/or improve health status.

The roles, responsibilities and accountabilities of AHS are outlined in the Alberta Health Services Mandate and Roles Document. AHS is required to prepare and submit to the Minister of Health an Annual Report in compliance with legislation, reporting how AHS has discharged its legislated responsibilities and any other responsibility delegated by the Minister. The Annual Report is approved by the AHS Board and then submitted to the Minister who then tables the report in the Legislative Assembly.

All programs and facilities, whether owned and operated by AHS, non-profit organizations or private groups are operated in compliance with specific sections of program legislation. The legislative responsibilities of AHS are outlined in Section 5 of the Regional Health Authorities Act. AHS is accountable to:

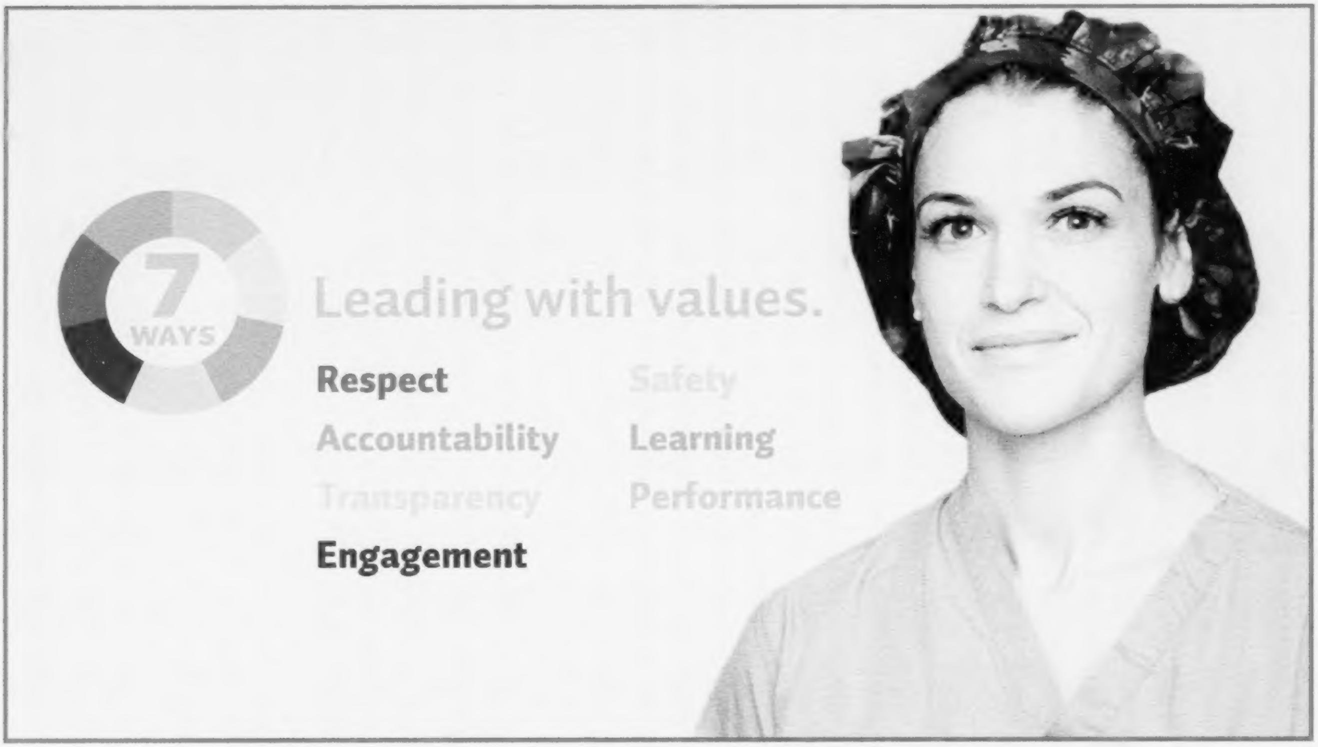
- Assess on an ongoing basis the health needs of Albertans
- Determine priorities in the provision of health services in Alberta and allocate resources accordingly
- Ensure that reasonable access to quality health services is provided in and through Alberta
- Promote and protect the health of the population in Alberta and work toward the prevention of disease and injury
- Promote the provision of health services in a manner responsive to the needs of individuals and communities and supports the integration of services and facilities in Alberta

Mission, Values and Strategic Direction

The Mission of Alberta Health Services is:

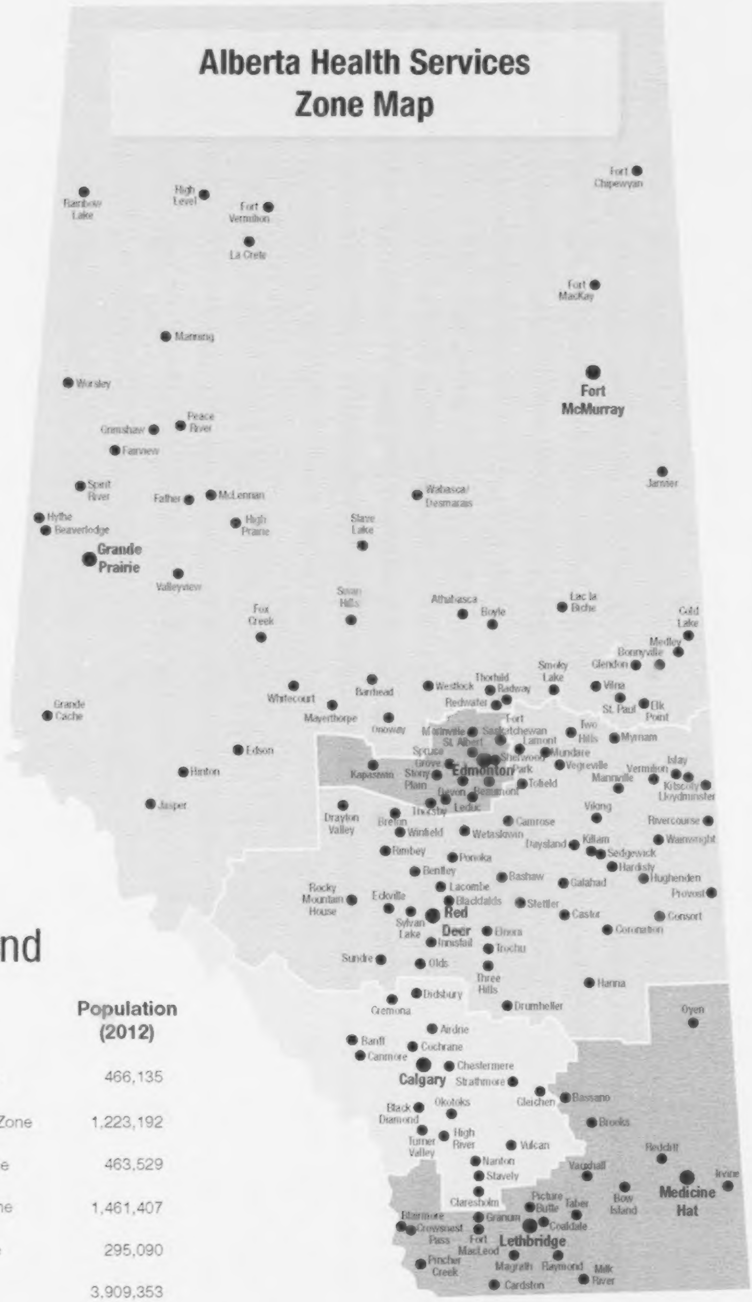
To provide a patient-focused, quality health system that is accessible and sustainable for all Albertans.

Our values make us who we are. They drive us, unite us and are the essence of our culture. Our values define what we believe in and what we stand for. They provide us with a common understanding of what is important and anchor our thinking. We use our values to lead our work, our actions and our decisions. Our seven core values are: respect, accountability, transparency, engagement, safety, learning and performance.



A refresh of the AHS 2013-2016 Health Plan and Business Plan, including strategic directions, was approved by the AHS Board in April 2013. Working together with Alberta Health, we focused on three dimensions in improving health care: improving patient experience, improving health outcomes and improving value for money. These high-order dimensions inform our strategic directions going forward: bringing care to the community, establishing a partnership in health and achieving sustainability. The 2013-2016 Health Plan and Business Plan was shared across AHS and with Albertans in May 2013.

Alberta Health Services Map


Alberta Health Services Zone Map
Rainbow Lake
High Level
Fort Vermilion
La Crete
Fort Chipewyan
Fort MacKay
Manning
Worsley
Fort McMurray
Grimshaw
Peace River
Fairview
Spirit River
Falher
McLennan
Wabasca/Desmarais
Janvier
Hythe
Beaverlodge
High Prairie
Slave Lake
Grande Prairie
Valleyview
Swan Hills
Athabasca
Boyle
Lac la Biche
Cold Lake
Fox Creek
Medley
Bonnyville
Glendon
Smoky Lake
Thorhild
Radway
Westlock
Barrhead
Whitecourt
Vilna
Redwater
St. Paul
Elk Point
Mayerthorpe
Grande Cache
Onoway
Fort Saskatchewan
Two Hills
Myrnam
Morinville
St. Albert
Lamont
Mundare
Edson
Spruce Grove
Sherwood Park
Vegreville
Vermilion
Islay
Kapasiwin
Stony Plain
Edmonton
Mannville
Kitscoty
Lloydminster
Hinton
Devon
Beaumont
Tofield
Jasper
Thorsby
Leduc
Viking
Drayton Valley
Breton
Camrose
Rivercourse
Winfield
Wetaskiwin
Daysland
Killam
Wainwright
Rimbey
Ponoka
Sedgewick
Bentley
Hardisty
Bashaw
Hughenden
Lacombe
Galahad
Provost
Rocky Mountain House
Eckville
Blackfalds
Stettler
Sylvan Lake
Red Deer
Castor
Consort
Innisfail
Elnora
Coronation
Trochu
Sundre
Olds
Three Hills
Hanna
Didsbury
Cremona
Drumheller
Oyen
Airdrie
Banff
Cochrane
Canmore
Chestermere
Calgary
Strathmore
Gleichen
Bassano
Black Diamond
Okotoks
Brooks
Turner Valley
High River
Vulcan
Redcliff
Nanton
Vauxhall
Irvine
Stavely
Medicine Hat
Claresholm
Picture Butte
Taber
Bow Island
Blairmore
Granum
Coaldale
Crowsnest Pass
Fort MacLeod
Lethbridge
Pincher Creek
Magrath
Raymond
Milk River
Cardston

legend

		Population (2012)
▨	North Zone	466,135
▨	Edmonton Zone	1,223,192
▨	Central Zone	463,529
▨	Calgary Zone	1,461,407
▨	South Zone	295,090
	Alberta	3,909,353

Quick Facts

ALBERTA HEALTH SERVICES	2010-11	2011-12	2012-13	% CHANGE 2011-12 TO 2012-13
PRIMARY CARE / POPULATION HEALTH				
Home Care Clients	97,326	104,089	108,855	5%
Health Link Calls	758,971	766,146	755,980	-1%
EMS Calls/Events	377,280	393,964	416,160	6%
Seasonal Influenza Immunizations	832,679	875,984	919,348	5%
Public Health Inspections (all programs)[a]	146,293	148,301	160,793	8%
ACUTE CARE				
Emergency Department Visits (all sites)	1,942,003	2,029,225	2,116,474	4%
Urgent Care Visits	177,297	196,268	204,446	4%
Hospital Discharges	364,052	376,126	385,497	2%
Births	49,756	50,101	51,541	3%
Total Hospital Days	2,544,850	2,602,507	2,640,201	1%
Average Length of Stay (in days)	7.0	6.9	6.8	-1%
DIAGNOSTIC/SPECIFIC PROCEDURES				
Total Hip Replacements (scheduled and emergency)	4,488	4,912	5,216	6%
Total Knee Replacements (scheduled and emergency)	5,025	5,836	6,114	5%
Cataract Surgery	33,781	36,562	34,465	-6%
Main Operating Room Activity	251,453	265,568	263,196	-1%
MRI Exams[b]	177,422	166,645	176,705	6%
CT Exams	333,163	334,614	344,667	3%
X-rays[b]	1,797,335	1,869,309	1,815,295	-3%
Lab Tests	61,357,627	65,282,456	68,350,334	5%
CANCER CARE				
Cancer Patient Visits	524,420	547,093	560,927	3%
Cancer Patients Receive Treatment, Care & Support	46,889	48,421	50,107	3%
ADDICTION & MENTAL HEALTH				
Mental Health Hospital Discharges (acute care sites)	18,647	19,251	19,934	4%
Community Treatment Orders (CTO) Issued	98	200	274	37%
Addiction Residential Treatment & Detoxification	9,004	9,851	10,044	2%

Notes:

[a] Environmental Public Health delivers inspections and interventions in seven program areas (Safe Food, Safe Drinking Water, Safe Built Environments, Safe Indoor Air, Healthy Environments, Safe Recreational Water and Disease and Injury Control).

[b] MRI exam (in 2011-12) and X-ray (in 2012-13) count converted to new methodology from the Common Procedures Exam List (CPEL) to the Canadian Institute for Health Information (CIHI).

CIHI Interesting Facts

The Canadian Institute for Health Information (CIHI) is a not-for-profit organization that helps to improve the Canadian health system and the well-being of Canadians by being a leading source in the development and maintenance of comprehensive and integrated health information that enable health leaders to make better-informed decisions.

CIHI released results from the most recent Canadian Hospital Reporting Project (CHRP). The report tracks a series of clinical and financial indicators. Alberta performed among the top three provinces in eight of the 21 clinical indicators for the most recent year of tracking (2011-12 or 2010-11, depending on the indicator).

- Alberta is the top-performing province in Canada with the lowest 30-day hospital readmission rate for patients 19 years of age and younger.
- Alberta continues to lead in Canada for having the lowest 30-day rate of in-hospital mortality after a patient has had a stroke or a heart attack.
- Alberta has the second lowest 30-day hospital readmission rate for pregnant women and new mothers following childbirth.
- Alberta has the third lowest rates of all the provinces for:
  - 28-day hospital readmission following a heart attack.
  - 30-day hospital adult-medical readmission.
  - 30-day overall hospital readmission.
  - in-hospital hip fracture for patients aged 65 and over.

In December 2012, CIHI released Hospital Standardized Mortality Ratio (HSMR) data for 82 acute care hospitals across Canada, including nine Alberta hospitals. The national HSMR average is weighted to be 100; an HSMR value of less than 100 is considered to be better than the national average. In Alberta, HSMR improved from 93 in 2010-11 to 88 in 2011-12, well below the weighted national average of 100, and steady improvement has been seen over the past three years. Eight of the nine Alberta hospitals with individual distinct data included in the report either improved or stayed about the same; one Alberta hospital showed a year-over-year increase.

The Hospital Standardized Mortality Ratio (HSMR) is a ratio that indicates how successful hospitals and health regions have been in reducing inpatient deaths—leading to improved patient care. HSMR is intended as a tool to help all hospitals and health care organizations strive to continually improve patient care within each individual hospital. CIHI leads the effort in calculating HSMRs for Canada and publishes results for eligible facilities and regions in all provinces.

Bed Numbers

NUMBER OF BEDS/SPACES	AS OF MARCH 31, 2012	AS OF MARCH 31, 2013	DIFFERENCE	% CHANGE
ACUTE & SUBACUTE CARE				
Acute Care	8,114	8,230	116	1.4%
Subacute in Auxiliary Hospital	525	511	-14	-2.7%
Total Acute & Subacute Care	**8,639**	**8,741**	**102**	**1.2%**
CONTINUING CARE				
Long Term Care	14,613	14,554	-59	-0.4%
Supportive Living Level 3	1,580	1,552	-28	-1.8%
Supportive Living Level 4	3,898	4,531	633	16.2%
Supportive Living Level 4 - Dementia	1,585	1,896	311	20%
Subtotal Supportive Living	**7,063**	**7,979**	**916**	**13.0%**
Subtotal Long Term Care & Supportive Living	**21,676**	**22,533**	**857**	**4.0%**
Community Palliative and Hospice (outside a hospital)	182	202	20	11.0%
Total Continuing Care	**21,858**	**22,735**	**877**	**4.0%**
ADDICTION AND MENTAL HEALTH				
Psychiatric (stand-alone facilities)	918	978	60	6.5%
Addiction Treatment	802	810	8	1.0%
Community Mental Health	522	539	17	3.3%
Total Addiction & Mental Health	**2,242**	**2,327**	**85**	**3.8%**
ALBERTA TOTAL	32,739	33,803	1,064	3.2%

Source: AHS Bed Survey as of March 31, 2013

Notes:
Acute Care bed numbers revised from 8,118 to 8,114 due to previously incorrect reported beds.
Psychiatric - stand-alone facilities revised from 884 to 918 due to exclusion of addiction beds.
Addiction numbers revised from 830 to 802 due to previously incorrect reported beds.
Community Mental Health numbers revised from 514 to 522; due to previously incorrect reported beds.
Continuing Care bed numbers revised from 21,683 to 21,676; due to previously incorrect reported beds.
Palliative bed numbers revised from 181 to 182; due to previously incorrect reported beds.

For more information on facilities and beds by Zone, please see Appendix.

Board Governance

The AHS Board supports the Minister of Health's mandate to improve access to care and to create a sustainable health system. The AHS Board reports directly to the Minister.

The Board fulfills its governance role by overseeing and providing direction to senior executives in the delivery of services that improve access, quality, safety and sustainability of heath care for Albertans. The Board acts in the best interests of AHS and is responsible for its stewardship, including, but not limited to, determining the vision, mission and values, promoting good governance, and meeting the duty of care to preserve the assets and maintaining the integrity of management and financial systems. The Board has the responsibility for ensuring effective governance of AHS and of the Board itself and is responsible for establishing and maintaining effective relationships with the Alberta Government, health professionals and other key stakeholders.

The following is a list of Board Members who were part of the AHS Board for the fiscal year ended March 31, 2013.

AHS BOARD MEMBER	DATES ACTIVE
Stephen H. Lockwood, Q.C.	Oct 2010-Sep 2012; Chair Sep 2012-Present
Catherine Roozen, B.Comm., LLD (Hon)	Vice Chair July 2008-Dec 2011; Interim Chair Dec 2011-Sep 2012; Vice Chair Sep 2012-Present
Dr. Ray Block, B.Comm., MAg, PhD, CGA	Feb 2011-Sep 2012
Teri Lynn Bougie, BA, LLB	Nov 2008-Mar 31, 2013
Dr. Ruth Collins-Nakai, MD, MBA, FRCPC, MACC, ICD.D	Feb 2011-Present
Donald Cormack, B.Comm., CA, ICD.D	Mar 2013-Present
Dr. Kamalesh Gangopadhyay, MD, MRCOG, FRCSC	Oct 2010-Mar 31, 2013
Don Johnson, BA, B.Sc.	Feb 2011-Present
John Lehners, P.eng., ALS	May 2008-Present
Fred Ring, BA, MEd.	Mar 2013-Present
Gary D. Sciur, Q.C.	Mar 2013-Present
Don Sieben, B.Comm., DHSA, MBA, FCA	May 2008-Present; Interim Vice Chair Jan 2012-Sep 2012
Dr. Eldon Smith, OC, MD, FRCPC	Feb 2011-Present
Sheila Weatherill, OC., BscN, LLD (Hon)	Feb 2011-Aug 2012
Gord Winkel, P.Eng., M.Sc.	Nov 2008-Mar 31, 2013

Alberta Health Services Board Committees include: Audit and Finance Committee, Quality and Safety Committee, Governance Committee, Health Advisory Committee, Human Resources Committee, and Committee of the Whole.

Alberta Health Services Board Members completed their annual assessment from a governance perspective, which included the effectiveness of Board Committees. This is a standard part of Board assessments and quality improvement.

Accreditation is a requirement for AHS. Based on a three-year rotating accreditation schedule, Board and Governance were priorities for the first year which began in 2010 and will be reviewed again in May 2014.

Advisory Councils

Health Advisory Councils

Each of the 12 Health Advisory Councils (HACs) established in 2009-10 consist of 10 to 15 members, including a Chair. Every HAC represents a different geographical area within the province.

HEALTH ADVISORY COUNCILS	GEOGRAPHICAL AREA	HAC CHAIR	TERM
1. True North Health Advisory Council	La Crete, High Level & Area	Joyce Fehr	Apr 1, 2012 – Mar 31, 2013
2. Peace Health Advisory Council	Peace River, Grande Prairie & Area	Theresa Sandul	Apr 1, 2012 – Mar 31, 2013
3. Lesser Slave Lake Health Advisory Council	Slave Lake, High Prairie & Area	Ken Matthews	Apr 1, 2012 – Mar 31, 2013
4. Wood Buffalo Health Advisory Council	Fort McMurray & Area	Iris Kirschner	Apr 1, 2012 – Mar 31, 2013
5. Lakeland Communities Health Advisory Council	Lac la Biche, Redwater, Cold Lake & Area	Deanna Anderson Marvin Fyten	Apr 1 – 30, 2012 May 1, 2012 – Mar 31, 2013
6. Tamarack Health Advisory Council	Hinton, Edson, Whitecourt & Area	Douglas Mcdermid Ruth Martin-Williams	Apr 1 – 30, 2012 May 1, 2012 – Mar 31, 2013
7. Greater Edmonton Health Advisory Council	Edmonton & Area	Lawrence Tymko	Apr 1, 2012 – Mar 31, 2013
8. Yellowhead East Health Advisory Council	Camrose, Lloydminster & Area	Colleen Vennard Don Whittaker	Apr 1 – 30, 2012 May 1, 2012 – Mar 31, 2013
9. David Thompson Health Advisory Council	Red Deer & Area	Bruce Buruma	Apr 1, 2012 – Mar 31, 2013
10. Prairie Mountain Health Advisory Council	Calgary & Area	Larry Albrecht	Apr 1, 2012 – Mar 31, 2013
11. Palliser Triangle Health Advisory Council	Medicine Hat & Area	Dr. Kenneth Sauer	Apr 1, 2012 – Mar 31, 2013
12. Oldman River Health Advisory Council	Lethbridge & Area	Dr. Barbara Lacey	Apr 1, 2012 – Mar 31, 2013

The mandate of the Health Advisory Councils is to support AHS in achieving its strategies by engaging members of the public in communities throughout Alberta, and providing advice and feedback from a local perspective on what is working well in the health care system and areas in need of improvement. Councils also promote and participate in activities that enhance the health of residents in the communities where we live. All council members are appointed by the AHS Board. More information about our Health Advisory Councils can be found under Community Engagement in the results section in the appendix.

Provincial Advisory Councils

Provincial Advisory Council on Cancer

Established in April 2011, the Provincial Advisory Council on Cancer has been effective in strengthening a good working relationship with the Alberta Health Services (AHS) Cancer Care System. Representing different areas across the province, the members bring their local knowledge and insight as they help identify opportunities within the community where cancer care services can be improved. As this Council continues to strengthen, it will be better informed and work more effectively in bringing advice forward regarding potential challenges, gaps, opportunities and strategic investment within the cancer services as provided by AHS.

The Provincial Advisory Council on Cancer has a limited ability to engage the public directly due to its broad provincial scope. Therefore, council members have chosen to extend their local knowledge of public members' views, opinions and insight to include new partnerships with the geographically defined Health Advisory Councils.

Several initiatives/projects underway within the AHS Cancer Care system were reviewed with Council members to assist them in developing future priorities for their consideration. Members are looking forward to the anticipated announcement by government of the Alberta Cancer Plan. The goals and strategies of the Plan will be critical to informing the council's work.

The Council on Cancer provided feedback to AHS on several initiatives this year, including the Alberta Cancer Plan, the Cancer Care Strategic Clinical Network, and the Colorectal Cancer Screening Program.

Provincial Advisory Council on Addiction and Mental Health

The Provincial Advisory Council on Addiction and Mental Health was established by the AHS Board in December 2011. After completing the appointment and recruitment process for its 15 members, the Council held its inaugural meeting in June 2012. The inaugural year has been effective in building foundational relationships with both the AHS Board and leadership. Continually nurturing these connections will enable the Council to be better informed and work effectively to seek and appropriately consider evidence and information from Albertans when advising on, and evaluating addiction and mental health planning, delivery and services.

In addition to completing the Council's organizational tasks, members have served on a number of committees that relate to the Council's mandate, including the Addiction and Mental Health Strategic Clinical Network, and the recently formed Patient Engagement Reference Group. Members have identified and prioritized key issues in addiction and mental health that are of concern to them and their public. This will assist the Council in how to best offer suggestions and ideas to make improvements to the system.

Council members have chosen to extend their local knowledge of public members' views, opinions and insight through the development of a public awareness campaign and with new partnerships. It has chosen to develop partnerships with the geographically defined Health Advisory Councils (HACs), communicating with each on a regular basis and attending HAC meetings, in order to extend its ability to bring public addiction and mental health related concerns forward.

The Council provided feedback to AHS on several topics this year, including the Provincial Elopement Safety Review, Electronic Health Records, Development of Consumer Tool, Improving Safety in Mental Health Units & Facilities and the Addiction & Mental Health Strategic Clinical Network.

2012-13 Organizational Structure

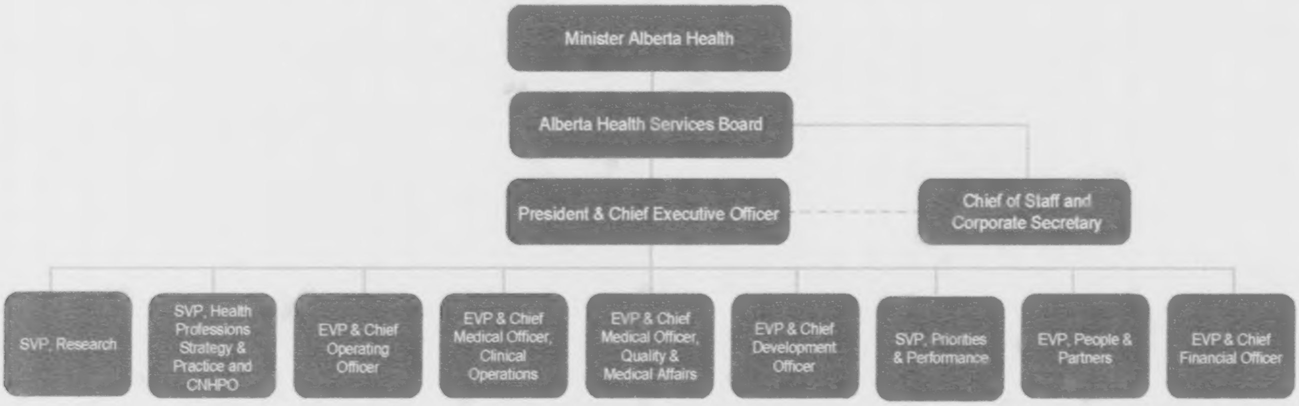
As the President and Chief Executive Officer of Alberta Health Services (AHS), Dr. Chris Eagle leads a staff of 104,000 caring and dedicated individuals who make up the AHS workforce. Dr. Eagle is responsible for leading health services through transformational change, shaping the future for AHS to allow achievement of the goals of access, quality and sustainability. He is also responsible to the Board for the organization's day-to-day operations.

AHS has realigned its senior leadership team to create a closer link between strategic planning and operations, and to enable more timely decisions at the local level.

Each portfolio is led by a member of the executive team, all reporting directly to the President & Chief Executive Officer.

Our governance structure is organized around the following leaders:

- Executive Vice President and Chief Operating Officer
- Executive Vice President and Chief Medical Officer, Clinical Operations
- Executive Vice President and Chief Medical Officer, Quality & Medical Affairs
- Executive Vice President and Chief Development Officer
- Executive Vice President, People and Partners
- Executive Vice President and Chief Financial Officer
- Senior Vice President, Research
- Senior Vice President, Health Professions Strategy & Practice and Chief Nursing and Health Professions Officer (CNHPO)
- Senior Vice President, Priorities & Performance


Minister Alberta Health
Alberta Health Services Board
President & Chief Executive Officer
Chief of Staff and Corporate Secretary
SVP, Research
SVP, Health Professions Strategy & Practice and CNHPO
EVP & Chief Operating Officer
EVP & Chief Medical Officer, Clinical Operations
EVP & Chief Medical Officer, Quality & Medical Affairs
EVP & Chief Development Officer
SVP, Priorities & Performance
EVP, People & Partners
EVP & Chief Financial Officer

(As of March 7, 2013)

The most recent Organizational Chart can be found on the AHS website.

PEDIATR
FOR WEIGHT &

Dawn Hersey, left and son, Brandon McMeckan, work with dietician, Janelle Stefanyk as they learn more about nutrition at the new Pediatric Centre for Weight and Health located in Calgary's Alberta Children's Hospital.

The Health of Albertans

The overall health of our population tells us a lot about where we can improve and where our resources need to be focused. Provincially, chronic disease, illness and injury contribute significantly to the burden on families, communities and our health care system.

As a health system, there is much we can do about these issues by strategically investing in promotion and prevention. We are working with communities, academic institutions, government and agencies across Alberta to support you in improving your health. Below are some of the significant ways we've helped you this year.

New centre provides weight-management support for youth:

More than 110 families have received weight-management support for their children at the Pediatric Centre for Weight and Health, located within Calgary's Alberta Children's Hospital. Opened in April 2012, the Centre brings together a team of specialists to help youth between the ages of two and 17 years reach and maintain a healthy weight and lifestyle. Currently, nearly 220,000 children in Alberta are either obese or overweight. Families with children who have weight-management issues can be referred to the Calgary centre, through a physician or nurse practitioner.

Get out and get walking:

In the past year, Walkable Alberta, a new AHS program, has helped five Alberta communities get moving. AHS health promotion facilitators, along with walking experts from partner organizations, engaged civic leaders and residents to address barriers to walking, such as the lack of proper paths and crosswalks, and improperly lit walkways, with a goal to make walking safer and easier and help build healthier communities.

The communities of Strathmore, Lethbridge, Carstairs, Plamondon and Red Deer all worked to make walking easier in their areas.

Enhancing supports for Albertans to become tobacco free:

Albertans wanting to quit or reduce their tobacco use have better access to resources and supports than ever before. Launched in December 2012, the new AlbertaQuits website offers 24/7 interactive features and information to support and provide guidance for those who want to quit using tobacco. Launched in conjunction with the website, the AlbertaQuits Facebook and Twitter accounts also reach hundreds of people each day. AHS continues to offer in-person support, including the successful QuitCore group support program.

Those being cared for at AHS facilities are also supported in becoming tobacco free. In 2011, AHS implemented its Tobacco and Smoke Free Environments policy, which prohibits the use of tobacco products on AHS property, helping to provide a safe and healthy environment for our patients, staff, physicians, volunteers and visitors.

To support nicotine dependent patients and clients in our care, AHS implemented the Tobacco Free Futures cessation model at AHS facilities. This model makes appropriate nicotine replacement therapy and medications available to clients and patients and ensures that patients are offered follow-up cessation services in the community when they leave our care.

AHS helps residents with chronic diseases to get active:

Since the fall of 2012, some residents of the Grande Prairie area, who have a chronic condition, or are at-risk of developing one, are feeling better and getting healthier through new group exercise classes offered by AHS. During each class, held at Grande Prairie Regional College in partnership with the Be Fit for Life Centre, AHS exercise therapists teach participants how to use portable exercise equipment correctly, how to safely engage in physical activity based on their current abilities, and how to make modifications to exercises based on their strengths, weaknesses and risk factors and chronic conditions. The classes are part of the AHS Alberta Healthy Living program, which also offers education sessions and chronic disease self-management workshops to help people manage chronic diseases. This program complements programs already operating in all zones.

Get Ready to Learn! and Get Ready to Read!:

More schools than ever before are catching delays in a child's learning in the Central Zone. Learning delays are spotted as soon as possible thanks to the AHS developed programs Get Ready to Learn! and Get Ready to Read! Last year, hundreds of kindergarten students took part in the program. This year, it's being used by speech-language pathologists and teachers in schools in more than a dozen Central Zone communities, reaching more than 300 kindergarten students. The program helps to identify children with potential delays in communication, helping them avoid and overcome communication disorders and language-learning difficulties.

Provincial Obesity Initiative:

Obesity currently costs the Alberta economy approximately $1.4 billion annually and is a serious health risk to over two million Albertans who are overweight or obese. As part of the AHS Obesity Initiative, a new adult bariatric specialty clinic has been established in Grande Prairie to support residents in the north of our province. This centre complements clinics already operating in Edmonton, Red Deer, Calgary and Medicine Hat to provide this service to the whole province. Bariatric specialty clinics support patients with medical weight management including changes in diet, exercise and in some cases support for bariatric surgery. ■

Facts at your Fingertips:

- Life expectancy has gone up in Alberta– Albertans born in 2012 are expected to live to 82 years of age.
- 44 per cent of Albertans are considered inactive and 25 per cent reported high levels of stress.
- From 2002 to 2012, Alberta's population has grown by 798,500 people.
- It is projected that by 2031, one in six Albertans will be over the age of 65.

Elder Phyllis Mustus, centre, who had a liver transplant, can now walk from home to get her monthly checkup with nurse practitioner Pamela Fald, right. Sharing in the group hug is Barb Paul, left, director of the Alexis Health Centre.

Health Care for Your Everyday Needs

Primary care is often called the front door to health care. It's a patient's first point of contact with health professionals. It could be an appointment with a family physician, a phone call to HEALTHLink Alberta or a visit to a local pharmacist, nurse, mental health professional or therapist. No matter how you receive it, primary care is the point where people receive care for most of their everyday health needs.

Primary care is more than just the front door. It is the foundation of a strong, sustainable and effective health care system. That's why strengthening Alberta's primary care foundation is a priority for Alberta Health Services (AHS). A strong primary care system will help you make informed choices about your health to live as fully and productively as you can.

Over the past year, we've been focused on improving your access to primary care.

Alberta Clinical and Surgical Assistant Program:

This new program provides international medical graduates with a six-month clinical assessment and evaluation opportunity in a supervised setting. Candidates are trained for acute (hospital) care coverage roles to address clinical and/or surgical coverage shortages. The program gives candidates valuable work experience and exposes them to professional health care in Canada.

New physicians:

Physician recruitment in areas of high need, such as rural and remote communities, is a challenge nationwide. In 2012, rural and urban facilities across Alberta welcomed over 400 new physicians, including two oncologists at the Jack Ady Cancer Centre in Lethbridge, a pediatrician in Fort McMurray, a plastic surgeon in Red Deer and two family physicians in Fairview.

Aboriginals benefit from renal outreach:

A nurse practitioner and a nephrologist spearheaded a weekly outreach prevention clinic for Siksika First Nation near Calgary to help people at high risk of developing chronic kidney disease, bringing care close to home. As of May 2012, the weekly nurse practitioner-led clinic is seeing more than 100 patients in the area. The success of the program has led to an expansion of services to the Blood First Nation in Standoff. The program is the first of its kind in the province and is part of AHS's plan to improve First Nations' health. The community of Siksika has the highest prevalence of diabetes in Alberta, at 15.1 per cent – three times the provincial rate. Diabetes is one of the most common causes of kidney disease. The clinic, developed by the Southern Alberta Renal Program (SARP), targets high-risk patients including people with diabetes, high blood pressure and high cholesterol. The Northern Alberta Renal Program (NARP) runs similar clinics in towns across northern Alberta, but these outreach prevention clinics are the only ones targeted specifically to First Nations communities.

Water birth in a hospital setting by local midwifery caregivers:

AHS and local midwifery caregivers offered water birth in a hospital setting as a trial option to Central Alberta women in three Central Zone facilities. Traditionally offered as a choice for homebirth clients by midwives across Alberta, four central Alberta midwives brought their expertise to the trial, which was undertaken in response to patient requests. The trial also included certification for physicians who were interested in the service and provided a valuable learning experience for nursing staff. As a result of this work, water births are now offered at Red Deer Regional Hospital Centre.

Family medicine residents:

Family medicine residents are working and learning at the Northern Lights Regional Health Centre as part of a new program to attract and retain family physicians in the Wood Buffalo area. The Family Medical Residency Program provides specialized training to prepare physicians for practicing family medicine in rural Alberta. The two-year program is a collaboration between AHS, the Wood Buffalo Primary Care Network and the University of Alberta.

Aboriginal Women's Outreach Clinic:

Aboriginal women of the Alexis and Paul First Nations enjoy more comprehensive health care close to home thanks to two new on-reserve clinics developed through a partnership between AHS, Health Canada, WestView Primary Care Network and First Nations communities. These Aboriginal Women's Outreach clinics, led by a WestView Health Centre-based nurse practitioner, have greatly boosted access to primary care and eliminated transportation obstacles for many patients. Services available at the clinic include annual Pap screenings, diagnostic testing, screenings for sexually transmitted infections, health assessments, and referrals for ultrasounds, x-rays, minor surgical procedures and birth control. Prenatal care is also an important focus of the clinics.

The full-day clinics alternate weekly between the Alexis First Nation, and the Paul First Nation, both near Stony Plain. The clinics collaborate with the women's family physicians and their other care providers to ensure continuity of care.

Family Care Clinic boosts local primary health care access:

Slave Lake residents have improved access to medical care for their everyday health needs since the opening of the Slave Lake Family Care Clinic (FCC) in May 2012. The FCC offers extended hours, giving individuals and families another primary health care option if their family doctor is unavailable, or if they do not have a family doctor. Previously, many residents would visit the emergency department at the Slave Lake Healthcare Centre for after-hours care of non-urgent medical conditions. Family Care Clinics also opened in Calgary at the East Calgary Health Centre and in Edmonton at the East Edmonton Health Centre in 2012. ■

Facts at your Fingertips:

- There are now three Family Care Clinics with over 21,000 Albertans enrolled.
- There are now 41 Primary Care Networks in Alberta, with 3,120 family physicians and 20 pediatricians.

Challenge By Choice participants, from left, Mary Lokolowski, Alex Nishuck, Kristina Toms and Jennifer Pothier. The program aims to help people with mental health illnesses or disorders.

Improving How We Provide Addiction and Mental Health Treatment and Support

Each year, more than 660,000 Albertans visit a doctor about their mental health. Because we are all unique, we are working to ensure that the treatment Alberta Health Services (AHS) offers meets the needs of individuals. We have found new and distinct ways to help prevent and treat addiction and mental health-related illnesses. Our goal is to find the right balance for every Albertan.

Creating Connections:

Alberta's Addiction and Mental Health Strategy, in partnership with Alberta Health built on a solid foundation to create an even stronger addiction and mental health system over the past year. Creating Connections established priorities under five strategic directions: build healthy and resilient communities; foster the development of healthy children, youth and families; enhance community-based services, capacity and supports; address complex needs and enhance assurance. In year one of this initiative, Alberta Health Services has already seen positive changes, such as the adult depression pathways in primary care networks which utilize partnerships between family physicians and behavioral health consultants.

Additionally, utilization of telehealth psychiatric services has provided increased access for Albertans. A housing and supports framework has been drafted to support homeless individuals to access personal identification needed for services and individuals affected by postpartum depression will be better served through the implementation of a clinical practice guideline. Work is continuing on several other initiatives to address these strategic priorities.

Mental wellness among youth:

The "tween" and teen years are a time of discovery, but often not easy for youth. With the pressures of growing up, students face new stress and worries about themselves and others.

Junior high school students and their teachers in Edmonton and surrounding communities received a new resource in November 2012, to promote mental wellness and tolerance among youth. The Junior High Mental Health kit, "Be Kind to Yourself and Others", developed in part by AHS, is a CD that contains printable information, lesson plans and student activities. Kits are being distributed to about 530 junior high schools throughout the Edmonton Zone to be used in health and life skills class curriculum throughout the school year, reaching about 200,000 students between the ages of 12 and 15.

Support for older adults with addiction, mental health issues:

A new local housing facility is now providing affordable, lodge-level care for up to 38 people, ages 55 to 65, who have addiction and/or mental health issues. Ottewell Manor, which opened fall 2012 in Edmonton, is the result of a multi-partnered housing initiative involving Greater Edmonton Foundation Seniors Housing, AHS, and Alberta Municipal Affairs.

Junior high students in tune with needs of dementia patients:

Local junior high school students in Grande Prairie are helping to unleash the therapeutic powers of music by collecting portable music players for use by dementia patients under the care of AHS. The donated MP3 players will be loaded with music familiar to individual dementia patients and used as part of regular music therapy. Familiar music tends to change behaviour in a positive way for patients with dementia and can be a calming influence.

The Adult Depression Pathway:

Developed by AHS's Addiction and Mental Health Strategic Clinical Network, the Adult Depression Pathway was launched in August 2012 to help local family physicians determine the nature and severity of a patient's depression, and outline the best course of treatment based on that patient's specific set of symptoms. This could involve introducing or adjusting medications, meeting with a behavioral health consultant (psychiatrist, psychologist, psychiatric nurse or clinical social worker), and/or providing patients with educational materials to assist with ongoing self-management.

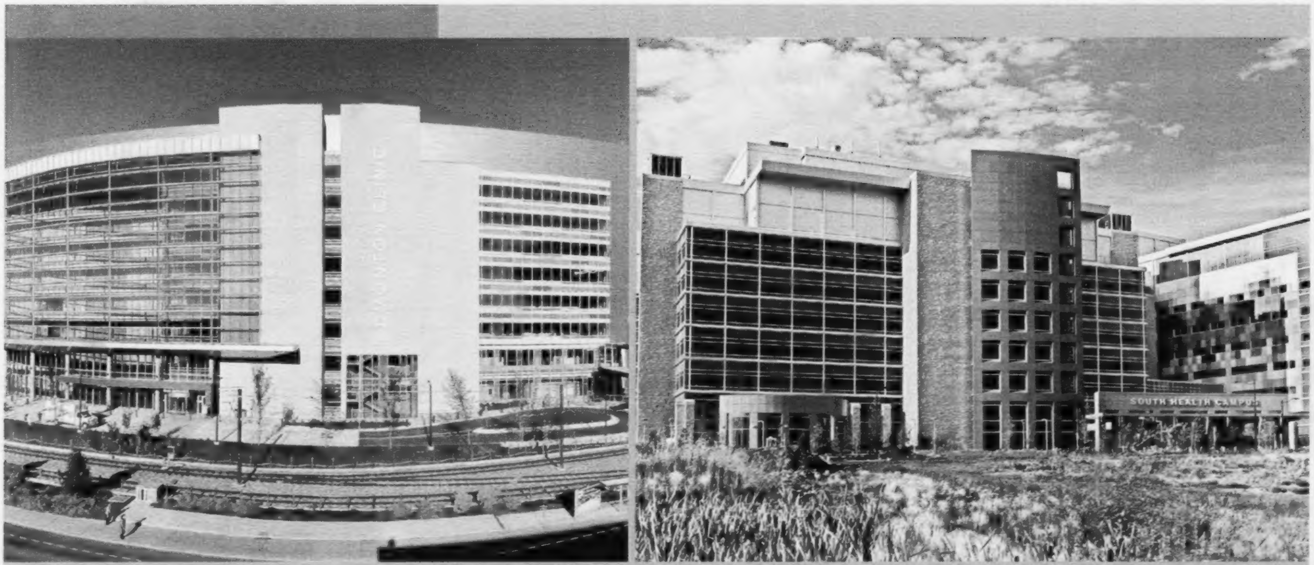
During a year-long pilot of the pathway in Calgary, 53 per cent of people seeking help for mild symptoms of depression, and 70 per cent of people seeking help for more severe symptoms, saw a behavioral health consultant at least once, compared to only 25 per cent before the pathway was launched. The pathway builds upon the partnership between family physicians and behavioural health consultants in physician clinics and primary care networks. This partnership means many patients can consult with someone who specializes in mental health in the same clinic where their family doctor practices. Pathways are currently being used in Calgary, Sherwood Park, Taber, Lethbridge and Peace River.

Choices target mental health:

Mental illness can affect any Albertan, regardless of age, race, culture, education or economic status. According to the Canadian Mental Health Association, youth are especially vulnerable to a mental illness or disorder and an estimated 10 to 20 per cent of Canadian youth are affected. The Challenge by Choice program is available to people aged 16 to 30 years of age suffering from a range of mental health concerns. Supported by the Mental Health Foundation in Edmonton, the program offers a group-friendly atmosphere and free social, learning and recreation activities with a focus on positive mental health and removing barriers. ■

Facts at your Fingertips:

- Nearly 55,000 individual Albertans accessed emergency departments for a substance use or mental health problem, including those with suicidal presentations, generating more than 80,000 visits.
- For every death by suicide in Alberta, there were 15 attempts.



The Kaye Edmonton Clinic, pictured on the left, provides the Edmonton area and northern Alberta with improved patient care and access to specialized services and technologies, while the South Health Campus, opened in Calgary, is redefining health care delivery in southern Alberta with leading technology, research and education in a unique healing environment.

Improving Access and Reducing Wait Times for Key Services

You don't like waiting and we don't either. As a provincial organization, we are able to connect health care professionals and patients across Alberta to reduce waits, improve access and make sure safe, high-quality care is accessible in every community of the province. We are reducing wait times for key services such as cataract and heart surgery, cancer radiation therapy, hip and knee surgery and emergency departments because we know that quicker access to services can mean better health outcomes for Albertans. As highlighted below, we have also added some very important capacity in the province this year, which will ultimately improve how quickly, and where, you can access the services you need.

Kaye Edmonton Clinic a one-stop shop for outpatient services:

Opened in December 2012, the Kaye Edmonton Clinic combines a wide range of services, health professionals, medical students and researchers under one roof. A range of outpatient services are available at the clinic, including orthopedic, day surgery, family medicine and seniors clinics. When fully operational, nearly one million patient visits a year will happen within an integrated network of care located all in one place.

Capacity triples for PET/CT scans in Calgary:

Southern Albertans with cancer and neurological diseases now have improved access to a powerful diagnostic tool. Calgary's second positron emission tomography/computed tomography (PET/CT) scanner, which went into operation at Foothills Medical Centre in May 2012, will perform 2,100 additional scans each year, bringing the number of total annual scans to 5,460 by September, a 62.5 per cent increase in capacity.

South Health Campus opens its doors in Calgary:

Since August 2012 South Health Campus (SHC) has opened over 55 new clinics and services, including the Intensive Care Unit and some surgical suites. In January, the SHC emergency department opened its doors and is seeing on average between 120-180 patients a day (30 per cent of those visits are to the pediatric clinics). After six months, the SHC Neurosciences Clinic has already seen over 3,000 patients, the Academic Family Medicine Clinic has seen about 4,000 patients and more than 10,200 diagnostic imaging exams have been performed.

As of early spring 2013, 113 inpatient beds have opened at SHC with a total of 269 expected to be opened by fall 2013. When SHC is fully operational, it is expecting 200,000 outpatient visits a year.

Pediatric brain-tumour clinic a 'home base' for families:

With its one-stop approach, the Pediatric Neuro-Oncology Monitoring Clinic at Stollery Children's Hospital ensures consistency of care. Familiar, friendly faces get get to know the family well as care providers keep a watchful eye on a child's health both during treatment and for months and years afterwards with ongoing check-ups. Opened in October 2012, the clinic also reflects the growing role of nurse practitioners at AHS. They are highly-qualified nurse specialists who are able to diagnose, order tests, prescribe treatment and medication as they manage independent clinics and carry their own patient caseload.

This clinic has become a welcoming, knowledgeable home base for families as it helps them to navigate what used to be a more time-consuming, complicated care pathway.

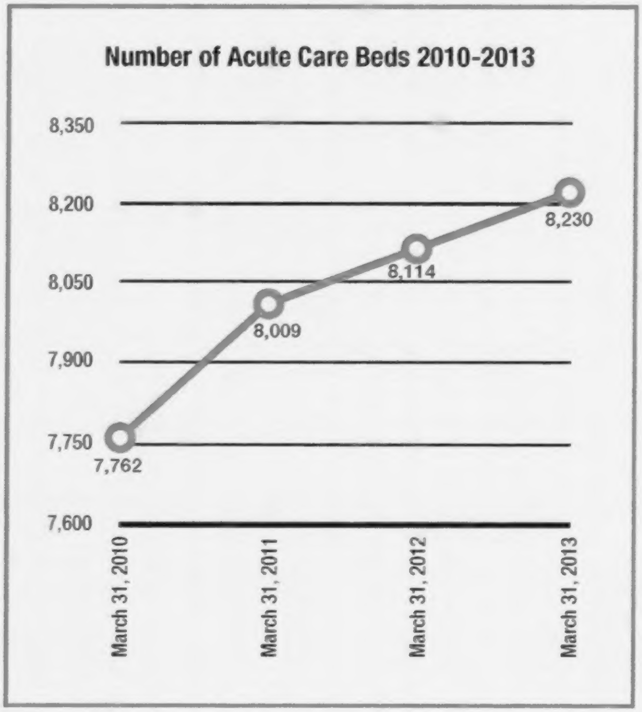
Stroke Support:

Over the last year, stroke patients in central Alberta are recovering faster and going home sooner since Red Deer Regional Hospital Centre introduced a new model of care that draws expertise from across the province. Over the past three years, the average length of acute care stay for stroke patients has decreased from 9.5 days to six days - a 37 per cent improvement.

Survivors of mild to moderate strokes can now leave hospital sooner and return to the comforts of home knowing a comprehensive AHS team will come to them with all the tools needed to work towards restoring their abilities, confidence and independence.

Red Deer Regional Hospital Centre is one of 15 primary stroke centres in the province, where local physicians and staff can connect via videoconferencing with stroke neurologists and other specialists in Calgary and Edmonton to provide faster diagnosis and treatments.

Alberta has the lowest 30-day in-hospital mortality rate following stroke in Canada, according to the Canadian Institute for Health Information.



Urgent Care Centre, East Edmonton Health Centre:

A new Urgent Care Centre, the first in the City of Edmonton, opened at the East Edmonton Health Centre in November 2012, to treat unexpected, potential life-threatening conditions that need same day attention, but do not require a visit to the emergency department.

About 20,000 urgent care visits a year are expected at the centre, representing a significant increase in improving access to urgent after-hours health care services in this community. The East Edmonton Health Centre also recently opened a Family Care Clinic which provides the opportunity to link patients with a primary care physician if they do not already have one.

New Fort Saskatchewan Community Hospital:

The new Fort Saskatchewan Community Hospital officially opened in April 2012, giving area residents enhanced access to the health care services they and their families need.

With more than triple the space of the former facility, the new Fort Saskatchewan Community Hospital offers 32 acute-care beds, with capacity for expansion to 38. As well, emergency services are available day and night, around the clock. Additional services offered at the new Fort Saskatchewan hospital include: IV Therapy Clinics, obstetrics, general surgery, ophthalmology including cataract surgery, radiology, rehabilitation, pharmacy and laboratory services.

Sturgeon Community Hospital Phase 2 Redevelopment Project:

The Sturgeon Community Hospital Phase 2 Redevelopment Project was completed in November 2012. The project included completion of a minor treatment area in the new emergency department, a new hospital main entrance, health records, administration, and gift shop areas.

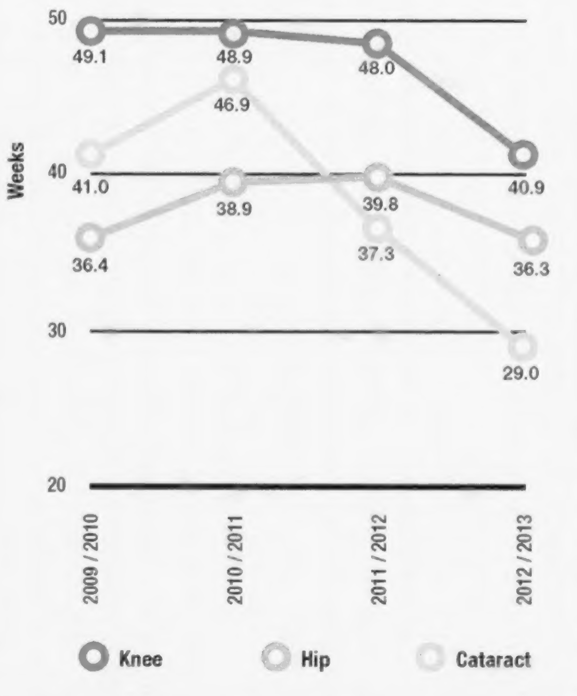
2012-13 Emergency Department Update:

The total number of visits to the province's emergency departments has increased by about four per cent when comparing 2012-13 to the prior year, while wait times have remained stable. The proportion of patients discharged within four hours at higher volume sites is 65 per cent, up from 63 per cent in 2009-10. The proportion of patients admitted within eight hours at higher volume sites is 45 per cent, up from 38 per cent in 2009-10.

2012-13 Surgery Update:

The wait time for 90 per cent of the people who require a hip replacement is down to 36.3 weeks this year, compared to 39.8 weeks in 2011-12. The wait time for knee replacement surgery is at the lowest point in the past two years, with an annual wait time of 40.9 weeks compared to 48.0 weeks in 2011-12. The number of hip and knee replacements has increased by nearly 19 per cent compared to two years ago. The wait time for cataract surgery is 29.0 weeks this year, down from 37.3 weeks at the same time in 2011-12, a 22 per cent improvement. More than 34,400 cataract surgeries have been done in 2012-13. ■

Surgery Wait Times 2009-2013



Dr. Kevin Hildebrand watches hip fracture patient Wauna Boyer during her rehabilitation exercises.

Improving How We Work Together Across the Province

We have laid the foundation for the future of health care by bringing the province's former health systems together, united in our goal to deliver high-quality health care to Albertans. We are a large and complex organization – one of the largest in Canada. Every day, and in all areas of the province, significant progress is being made toward building a patient-focused, quality health system that is accessible and sustainable for all Albertans. We are continuing to find ways to improve how we work together within Alberta Health Services (AHS), to make sure we have the best resources available to serve you.

More full-time positions:

AHS ramped up efforts to hire more full-time nurses, including new graduates, to meet the increasing demands on the system as our province grows and population grows and ages. More full-time positions mean patients and families will see the same nurses more regularly so they can really get to know their care team and feel more comfortable expressing care needs and preferences. Recently, at the newly-opened South Health Campus in Calgary, AHS filled 2,113 of the 2,853 jobs posted as full-time positions.

Local decision-making at Rockyview General Hospital:

A demonstration project launched in October 2012 at the Rockyview General Hospital provided an opportunity for local leaders to create a model from the ground up, to define and refine what an operating unit looks like and how it will work. Improved patient satisfaction, an engaged, innovative and energized workforce, the ability to respond quickly to patient and community needs, and more efficient operations are the targets of this work.

Chemical, Biological, Radiological, Nuclear/Hazardous Materials (CBRN/HazMat) planning:

In an emergency department, anything can happen—so it pays to be prepared. The CBRN/HazMat First Receiver program, first implemented in the Calgary Zone, was rolled out across other AHS zones in December. Its goal is to prepare all emergency departments and urgent care centre staff to treat patients who've been exposed to dangerous substances, and to protect themselves and other patients from further exposure. Once fully implemented, first receivers at all acute care and subacute care sites will be trained and equipped to recognize and respond to a CBRN/HazMat incident.

Coordinated continuing care access:

Coordinated Access is a provincewide, team approach to delivering continuing care that provides Albertans with reasonable, timely and appropriate access to continuing care health services. It includes standard processes for providing information; intake and screening; assessment; determining needs for service; negotiation of individual service options; service recommendation and referral; service delivery, monitoring and reassessment; transition; discharge; and waitlist management. As of January 2013, the North Zone Coordinated Continuing Care Access team is operating at full-capacity, providing service seven days per week. The team handles referrals through home care services, occupational therapy, physiotherapy and other allied health professionals.

Working with patients to improve the patient experience:

Strategic Clinical Networks (SCNs) are working to reshape health care in different areas of health to enhance the patient journey, improve outcomes and standardize care delivery across the province. There are currently 11 patient engagement researchers working with AHS's six SCNs, which are dedicated to improving the delivery of care in the areas of seniors' health, cancer care, cardiovascular health and stroke, addiction and mental health, bone and joint health, and obesity, nutrition and diabetes.

Nursing Locum Pilot:

A new pilot project is looking to get registered nurses some northern exposure. Made possible by an agreement between AHS and the United Nurses of Alberta, the North Zone Nursing Locum pilot project which launched in August 2012, allows registered nurses to choose short-term assignments in northern communities, including Fort Vermilion, High Level, La Crete, Paddle Prairie and Rainbow Lake.

The nurses can choose to work temporarily in several disciplines, including emergency, obstetrics, acute care and continuing care. Working in smaller communities allows nurses to take on more diverse roles, allowing them to gain experience in a variety of practice settings.

Aboriginal Wisdom Council engagement:

In September 2012, AHS appointed 19 members to the new Aboriginal Wisdom Council, established to give AHS guidance and recommendations on service delivery, program design and evaluation for province wide, culturally appropriate Aboriginal health services. The council gathers knowledge, ideas, opinions and stories to promote and preserve Aboriginal health and well-being. Similarly, a Provincial Advisory Council on Addiction & Mental Health was established. Council members represent a broad cross-section of Aboriginal society across Alberta and include physicians, dentists, nursing professionals, traditional healers, Elders, a former RCMP officer, business people, and a former Edmonton Eskimos football player.

eCLINICIAN:

The new Kaye Edmonton Clinic represents the first time in a large ambulatory facility that most clinics will use eCLINICIAN. This leading electronic medical record system allows clinicians to better coordinate care and share important patient information. The system will provide one consistent patient-centric system that most Edmonton Clinic clinicians share, making it easier and faster for interdisciplinary teams to coordinate patient care. The eClinician system will allow for sharing of data to inform delivery or care, research and to manage the health system in a manner that respects privacy.

eCritical:

eCritical is now live at all Calgary adult intensive care units. This system, which will eventually roll out in seven cities and 35 units, incorporates a bedside clinical information system and data warehouse. eCritical will give our care providers a better picture of a patient's condition and help them to update patient charts more easily.

e-People:

e-People is helping to make our provincial Human Resources (HR) and payroll system more efficient and consistent, and is giving managers easier access to up-to-date information. It also allows employees to access their HR information from work or home to update personal information, review benefits information and view and print pay stubs at their convenience. As of May 1, 2013, all 104,000 AHS staff are on the same system.

Patient satisfaction:

More Albertans are satisfied by the province's health system, according to the latest Health Quality Council of Alberta (HQCA) patient satisfaction survey. The 2012 HQCA patient satisfaction survey shows 64 per cent of Albertans indicated they were satisfied with the health services they received, compared to 62 per cent in the previous HQCA survey from 2010.

The top three factors that influenced Albertans' overall satisfaction rating were **access** to health care services, **quality** of health care services, and how well health care professionals **coordinate their efforts** to serve patient needs.

AHS standardizes high-quality care for hip fracture patients:

The establishment of the provincial Hip Fracture Care Pathway ensures Albertans who undergo hip fracture surgery will now receive the same high level of standardized care, regardless of where they live. Developed by the Bone and Joint Health Strategic Clinical Network of AHS, the pathway guides the patient journey at every step, from arrival in the emergency department to surgery to rehabilitation.

Introduced in December 2012, it aims for patients to receive surgery within 48 hours of sustaining a hip fracture 80 per cent of the time, and have patients up and moving with assistance, one day after surgery 95 per cent of the time.

Educational materials are provided to help patients and their families understand their care at every step. Care teams work closely together and with patients to plan early discharge from hospital, within five to seven days after their operation.

About 2,400 Albertans undergo hip fracture surgery every year. By safely reducing the length of time a patient spends in hospital, the pathway helps free up space and redirects resources to treat more patients.

The Hip Fracture Care Pathway is one of nine projects undertaken so far by AHS's six Strategic Clinical Networks (SCNs) and three Operational Clinical Networks (OCNs). ■

Facts at your Fingertips:

More Patient Satisfaction Survey Results

- Overall access: 51 per cent of respondents rated access to health care services as easy, up from 48 per cent in 2010.
- Quality of care: 77 per cent of respondents who received health care services in 2012 rated the quality of care as good or excellent, up from 75 per cent in 2010.
- Hospital care: 84 per cent of respondents rated the quality of their inpatient care during an overnight hospital stay as excellent or good, up from 79 per cent in 2010.
- Health Link: 78 per cent of respondents who used Health Link Alberta in the past year were satisfied with the telephone health information and advice service, up from 72 per cent in 2010.

Cancer patient Steven Renema, of Canmore, says his cancer patient navigator Isabelle Ramsay helped him through his treatment after being released from hospital.

Improving Care for Patients Facing Cancer

We want to reduce the impact of cancer on all Albertans and provide expert care and support for patients from their first symptom to survivorship. It's our goal to be a leader in cancer prevention, diagnosis, treatment, survivorship and palliative care, all on a foundation of world-class research. This year, we've introduced new and innovative ways to care for our cancer patients and have worked hard to prevent cancer from being a reality in the lives of Albertans.

Tablet computers replace sedation for young cancer patients:

Since June 2012, Alberta Health Services (AHS) radiation therapists are using tablet computers to reduce the number of pediatric cancer patients who require sedation before radiation therapy treatment. Many young patients now remain relatively still as they watch a favorite movie, TV show or cartoon during radiation therapy treatments, which can last up to 30 minutes per session.

Before radiation therapists began introducing tablet computers, almost all pediatric patients under the age of seven were sedated for treatment. In the last year, radiation therapists were able to eliminate sedation for five out of eight children between the ages of four and seven.

Star of the screen:

AHS launched a website in September 2012, to provide Albertans with detailed information about breast, cervical, and colorectal cancer screening and to help them decide if screening is right for them. The website - www.screeningforlife.ca - offers an interactive way to engage people with the facts about breast, cervical and colorectal cancer, and shows Albertans why screening is an important part of staying healthy. Visitors to the website can also find out what other factors may be impacting their cancer risk.

Mobile mammography service:

The Screen Test program is improving access to breast cancer screening for hundreds of women in communities across Alberta where mammography is not readily available. Early detection allows for a greater number of options for treatment and a better chance of survival. Women ages 50 to 69, the group most at risk of developing breast cancer, have local access to mammography services when a mobile screen test mammography trailer visits their community.

Help navigating cancer treatment in more communities:

Specially trained nurses have been placed in all 15 community cancer facilities across the province to be cancer patient navigators, helping guide patients through their treatment, follow-up care and beyond.

A cancer diagnosis can be a confusing and stressful event that gives rise to significant financial and practical problems. Patients must find their way through tests, appointments, treatments and services. AHS navigators are helping patients through this process in Fort McMurray, Peace River, Grande Prairie, Barrhead, Bonnyville, Hinton, Drayton Valley, Camrose, Red Deer, Drumheller, Canmore, High River, Medicine Hat and Lethbridge.

RapidArc:

Advanced treatment technology called RapidArc is now being used at the Cross Cancer Institute and Tom Baker Cancer Centre. The three new linear accelerators (linacs), installed in Edmonton and Calgary in late 2012 are capable of delivering radiation therapy faster and with improved accuracy. Radiation therapy can be given continuously and with remarkable precision while rotating around the patient, for faster, safer care. As an example, prostrate cancer patients receive treatments in less than two minutes, a quarter of the previous time.

The continuing development of Alberta's Radiation Therapy Corridor will also bring these state-of-the-art linear accelerators to Red Deer in 2013 and Grande Prairie in 2015. The corridor is expected to reduce the number of Albertans having to travel 100 km or more to receive radiation treatment from 28 per cent to about eight per cent.

In Alberta, 98 per cent of cancer patients receive their first radiation therapy treatment within the provincial benchmark of four weeks from when they are deemed ready to treat. One in every two patients has a first treatment in less than a week.

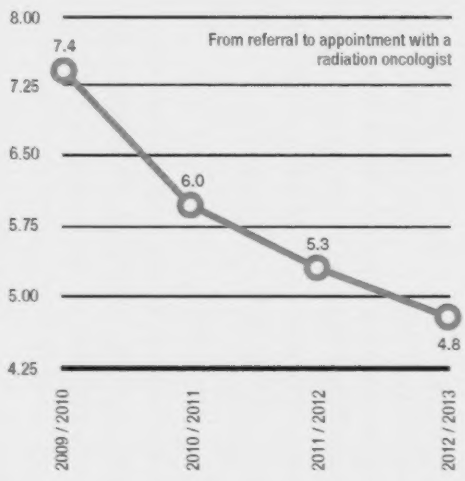
Better access to lung cancer services:

Patients suspected of having lung cancer are being diagnosed sooner at the Rapid Access Clinic, which opened at the Royal Alexandra Hospital. The clinic is part of AHS's Alberta Thoracic Oncology Program (ATOP). Wait times from the first appointment at the clinic to diagnosis have dropped and patients are now able to see a specialist sooner following a referral from a primary care physician. The clinic has three nurse practitioners who provide individualized care that addresses the physical and emotional toll of cancer diagnosis and treatment. The Edmonton Clinic, which also serves patients from northern and central Alberta, is based on a model used by a similar Rapid Access Clinic in Calgary, which has reduced wait times for lung cancer patients in southern Alberta. ■

Fact at your Fingertips:

- The wait time for access to radiation oncologist is at the lowest point in the past three years, with a wait time of 4.8 weeks in 2012-13 compared to 7.4 weeks in 2009-10.

Radiation Therapy Wait Times: 2009-2013



Herbert (Andy) Gillespie, lives at the Rimbey Hospital and Care Centre. He loves sauerkraut and pickles with every meal besides breakfast.

Improving Care When You Can No Longer Be at Home

Most Albertans enjoy good health, quality of life, and want to live independently as they age. Being able to remain in your own home, in your own community is important to you. Alberta Health Services (AHS) has worked to make that happen, by providing the right care in the right place and by listening to what you tell us what you want. Our aim is to offer a range of services to support choice, wellness and independence. We have adapted the range of continuing care services we provide to meet your changing needs, including home care, supportive living and long-term care.

Made to order:

Residents in many long-term care centres are enjoying improved menu selections, based on their preferences, as a result of the Closer to Home initiative. The initiative, developed by AHS in partnership with the Health Advisory Councils, canvassed residents, families, community members and facility staff on desired changes and improvements to menu selections at long-term care centres. About 290 people in 10 communities, representing all five zones of AHS, let their wishes be known over the summer of 2012. The resulting improvements were rolled out to 74 AHS long-term care centres in the fall of 2012.

Respite care is now available at the Vermilion Health Centre:

Previously, caregivers in this area of the province who were seeking long-term respite would need to place their loved ones in facilities in Islay, Mannville or Lloydminster. Now the Vermilion Health Centre can accommodate most patients, regardless of their medical needs, for up to three weeks. This adds to the already existing local respite services provided by home care staff in a patient's own home.

Home care expands to reach more clients in Medicine Hat:

In May 2012, home care services were bolstered in this southeastern Alberta community to double the number of home care staff, expand service hours in the evening, overnight and on weekends, and provide further support for frail patients. Over 108,800 Albertans were receiving home care services in 2012-13, compared to over 104,000 last year, an increase of 5 per cent. In Medicine Hat, seniors comprise about 15 per cent of the population; the provincial average is 10.7 per cent.

AHS home care services include short-term acute home care and rehabilitation (wound care, post-operative, medication administration), end-of-life care (including hospice palliative care), and long-term home care.

More local palliative beds with opening of Carmel Hospice:

Medicine Hat's first community hospice opened in November 2012, providing additional options and capacity to accommodate local residents approaching end of life, as well as support for their families and loved ones.

The 10-bed Carmel Hospice at St. Joseph's Home is operated by Covenant Health in partnership with AHS. The new beds supplement palliative services at the Medicine Hat Regional Hospital. In addition, ten palliative beds opened in October 2012 at Points West Living in Grande Prairie.

Palliative care helps patients and their families address the diverse physical, emotional, social and spiritual needs that accompany end-of-life and the dying process.

New capacity:

Alberta's seniors have more continuing care beds, more living options and more opportunities to be safe, healthy and independent in their own homes. AHS added 877 new continuing care and palliative beds in facilities across the province in 2012-13. Since 2010, AHS has opened 3,034 new beds.

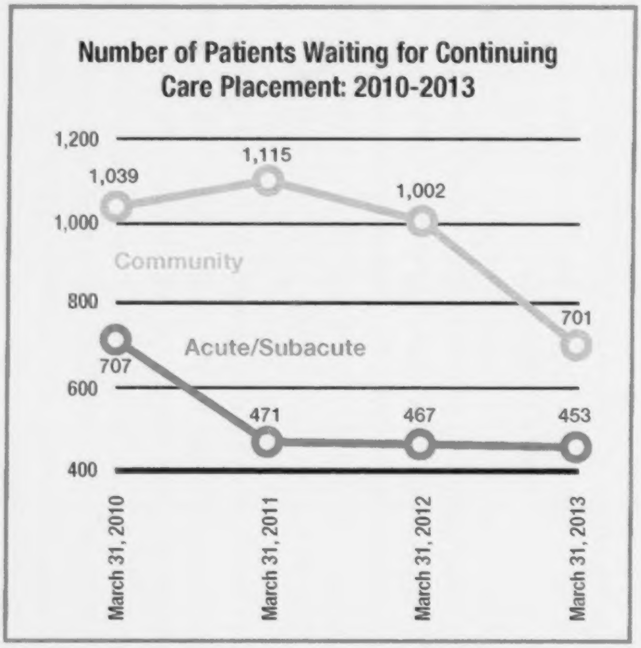
Adult day program supports dependent adults, caregivers:

Since December 2012, dependent adults in the Fort McMurray area, who live at home, can now enjoy therapeutic daytime activities while their caregivers receive much-needed respite, with the launch of a new adult day program. The Northern Lights Bridges Program gives dependent adults 50 years of age and older access to social and recreational activities, nursing and personal care assistance, and consultation with health care professionals, including a recreational therapist, physiotherapy assistant and nurses.

Adult day programs are offered across Alberta and have proven to make a positive impact on the lives of dependent adults and their caregivers. Through these programs, families who provide home-based care 24 hours a day, seven days a week have the opportunity to access support for their loved one in a safe and nurturing environment.

2012-13 Continuing Care Update

The number of people placed from hospitals into continuing care beds, has increased by nearly four per cent, comparing 2012-13 to the previous year. The percentage of people placed into continuing care within 30 days of being assessed is 67 per cent in 2012-13, up from 64 per cent during last year. ■


Number of Patients Waiting for Continuing Care Placement: 2010-2013

Sophie Chevalier, a neurology patient at the Alberta Children's Hospital in Calgary, was one of the first patients to experience the hospital's state-of-the-art 3T MRI scanner.

Community Support Enhances Patient Care

Alberta Health Services (AHS) relies on our 64 foundation and health trust partners to help drive innovation in health care. These organizations work diligently to gather community support, develop relationships and raise critically-needed funds to enhance care for patients and families. They are committed to building excellence in our system. Foundation donations fund many activities including the purchase of new equipment, renovations to patient and family lounges, and research into new care techniques. Below are a few examples of our foundations and trust partners at work around the province. A detailed list of our foundations and health trusts can be found in the Appendix section of this report.

Perfect alignment:

Fully funded by the QEII Hospital Foundation in Grande Prairie through the Robert Scott endowment, the Jackson Spine System is an innovative surgical table that keeps patients' bodies perfectly aligned on an operating table ready for spinal surgery. The table comfortably holds patients in place with padded brackets and straps, allowing medical staff to turn patients over and x-ray them without having to move them and compromise the spine. The table is not only safe for patients and staff, but the new design also means there are no metal bars hampering surgeons' view during a procedure.

Support for mental health:

Funded by the Mental Health Foundation in Edmonton, "Challenge by Choice" is a program offered to people 16-30 suffering from a variety of mental illnesses. The program provides participants social activities, in a safe, positive and caring environment where they can learn and practice positive life and social skills. Activities are facilitated by trained staff over broad disciplines, such as an occupational therapist, recovery therapist and referrals are made when needed e.g. addiction counsellors, food bank, sexual assault centre and crisis support.

Getting a better look at broken bones:

Through generous funding from the Rosebud Health Foundation, Didsbury District Health Services Centre now has a new mini C-arm that x-rays broken bones and provides physicians real-time video to accurately set broken bones. The mini C-arm is also mobile, allowing staff to go to patients and conduct treatment all in one room.

Home away from home:

The Medicine Hat & District Health Foundation, has provided funding to fully furnish a family room at the Maternal Child Unit at the Medicine Hat Regional Hospital. The family room provides the opportunity for families to stay together at the hospital when their children must stay in the hospital for an extended length of time. The room is furnished with a bed, TV, fridge, microwave, and room for a crib.

Breathing easier:

The Wainwright Health Centre now has a GlideScope, a small curved instrument with a flat blade attached to a handle that assists with the placement of breathing devices during emergency and routine medical procedures. Fully funded through the Wainwright and District Community Health Foundation, the GlideScope delivers life-saving breathing assistance to patients by ensuring the airway is open and clear for a breathing tube.

Powerful diagnostic technology for kids:

The Alberta Children's Hospital Foundation received tremendous community support for important clinical and research initiatives to help children faced with cancer, and injury and illness of the brain, or in need of enhanced pain and rehabilitation services and life-saving care. Donations enabled the hospital to acquire the first 3 Tesla Magnetic Resonance Imaging scanner within a children's hospital in western Canada. This new imaging technology provides specialists with the ability to visualize not only anatomical structures, but chemistry and function as well. It will help hundreds of children every year through enhanced research and care.

Outpatient care gets a boost in Edmonton:

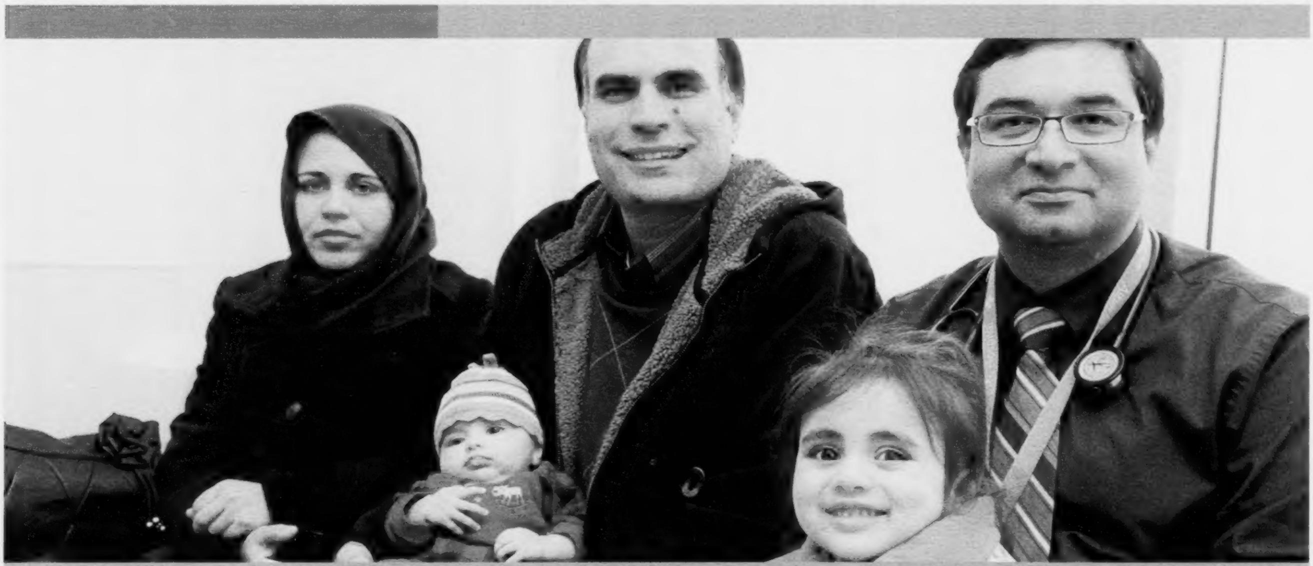
The University Hospital Foundation received the single largest donation ever given to health in the province of Alberta. In honour of the multi-million dollar gift from philanthropist Donald Kaye, the Edmonton Clinic was renamed the Kaye Edmonton Clinic. The donation will be used for education, research and advancements in outpatient care at the clinic.

Specialized care for women:

The Royal Alexandra Hospital Foundation has supported the creation of a second, highly specialized Colposcopy Procedure Room for the early detection of gynecological cancers through generous funding and support to the Lois Hole Hospital for Women. The specialized procedure room will increase the number of patients the hospital can treat and ultimately help diagnose and treat early those women with gynecological cancers.

The first OR of its kind in North America:

The Calgary Health Trust and the Government of Alberta have made possible the Interventional Trauma Operating Room (ITOR) now open at the Foothills Medical Centre – the first operating room in North American and the second in the world. More than twice the size of a traditional operating room, ITOR is a 150-square-metre, six-million suite specifically designed to control bleeding of patients with severe traumatic injuries, and includes its own angiography suite, allowing surgical and diagnostic imaging teams to work on a patient simultaneously. ■



It's big smiles all the way around from big sister Paghunda, mom, Alia and dad Jouhar Ali, following a life-saving liver cell transplant for baby sister, Nazdana. Dr. Aneal Khan performed the first-in-Canada procedure.

Advancing Health Care Through Innovation and Research

Through innovative projects, procedures, media and technology, we are shaping the largest integrated health system in Canada to provide better care for you. Innovation and research at Alberta Health Services (AHS) is achieved in partnership with our many stakeholders including the provincial universities, Alberta Innovates Health Solutions and Technology Futures, Foundations, not-for-profit funding agencies and industry sponsors. Innovative practices and research advances allow AHS to provide the most advanced health care to all Albertans.

Stents for opening blocked blood vessels:

Edmonton cardiologist Dr. Yashu Coe pioneered a new system for opening narrowing or blocked blood vessels that could revolutionize how this procedure is performed around the world for children and adults. Dr. Coe's stent delivery system is designed to provide better precision and control when moving the catheter through the body and into the heart. As a result, procedures are expected to be performed in less time, reducing the risk of complications.

Genetic markers for Autism:

Dr. Lonnie Zwaigenbaum, Edmonton autism researcher with the Glenrose Rehabilitation Hospital and the University of Alberta received a research grant to study autism in siblings. The award is in recognition of his work with scientists from across North America to find out whether genetic markers for autism exist by examining DNA samples from children with autism and their infant siblings.

Repairing leaky heart:

In an Alberta-first, local cardiac specialists are now repairing leaky heart valves using a minimally invasive procedure that reduces hospital stays, speeds recovery and leaves smaller scars.

The procedure for minimal-incision aortic and mitral valve repair was first performed in May 2012 at the Libin Cardiovascular Institute of Alberta, an entity of both AHS and the University of Calgary.

The procedure is used to treat mitral and aortic regurgitation, conditions in which blood leaks backwards through the heart valve, which can lead to irregular heartbeats (arrhythmias) or heart failure if left untreated. It involves making a four to five centimetre incision to the side of the chest, without cutting any bone. Instruments are then inserted and the valve is repaired via telescope.

Made-in-Alberta 'joystick' helps patients regain hand skills:

A made-in-Alberta therapy tool at the Glenrose Rehabilitation Hospital is helping accident, stroke, brain and spinal-cord injury patients to regain hand, arm and shoulder function. ReJoyce (Rehabilitation Joystick for Computerized Exercise) is a high-tech, spring-loaded arm with special handles and attachments that the patient moves, twists and squeezes to play customized video games that adapt themselves to the user's abilities, combining range of motion with finer dexterity tasks. The technology resembles a smaller version of the Canadarm used by the U.S. space shuttle program. The ReJoyce workstation also provides analysis after each session that helps therapists and patients to precisely measure and track progress. This information can also be used to develop strategies that help patients compensate for their impairments.

The $8,000 device was invented by two University of Alberta biomedical engineers, Dr. Arthur Prochazka, a physiology professor in the Centre for Neuroscience in the Faculty of Medicine and Dentistry, and Jan Kowalczewski, now a Postdoctoral Fellow in Physiology, with funding support from Alberta Innovates – Health Solutions.

Canada's first liver cell transplant takes place in Calgary:

A three-month-old Winnipeg girl has become the first patient in Canada to receive an experimental and potentially life-saving form of therapy to improve the function of her liver. The girl was born in August 2012 with a Urea Cycle Disorder (UCD), a genetic disease that causes ammonia to build up in the body that, if untreated, would lead to brain damage and death. The condition is incurable and very rare: Alberta Children's Hospital treats about two children with a UCD per year. In Canada, about 50 babies are born annually with the condition. The procedures took place over six days in November 2012 at Alberta Children's Hospital, with each infusion taking about an hour. Liver cell transplant therapy is part of a research trial. Dr. Khan, who performed the procedure, is a geneticist at the Alberta Children's Hospital, an assistant professor of medical genetics and pediatrics at the University of Calgary, and a member of the Alberta Children's Hospital Research Institute for Child and Maternal Health.

Virtual-reality fun leads to real-life improvements in children:

Young patients are now able to go mountain climbing and snowboarding without leaving Alberta Children's Hospital, with the help of a virtual-reality system designed to assist with rehabilitation and disease management.

IREX (Interactive Rehabilitation and Exercise System) uses green-screen technology to immerse patients in sports or gaming environments. It's more than just fun. These interactive exercise programs, prescribed by an AHS physical or occupational therapist, test for and build balance, mobility and endurance. Games can be customized for each patient. Some can be programmed to work only one part of the patient's body, such as a thumb after tendon repositioning surgery, or programmed to work the patient's entire body, which is often needed after a traumatic brain injury.

The IREX system was made possible by community support through the Alberta Children's Hospital Foundation.

Gene for Nager Syndrome:

Dr. Francois Bernier, a physician at the Alberta Children's Hospital who led a team of North American researchers, identified the gene that causes Nager Syndrome. The discovery has enabled scientists to develop the first test for the condition. Nager Syndrome causes deformation in a child's face and limbs.

The discovery allows experts from around the world to provide earlier and more accurate diagnosis for children and more accurate reproductive counselling to families, to develop tailored treatments for those with the syndrome and to work toward the development of drugs that will improve the lives of affected children.

This discovery was the result of an international collaboration between FORGE Canada and the University of Washington. FORGE Canada is a national consortium of clinicians and scientists, which includes Bernier's team.

Surgery dials down blood pressure:

In November 2012, the CK Hui Heart Centre at the Royal Alexandra Hospital in Edmonton became the first facility in Western Canada to perform renal denervation, a minimally invasive operation designed to treat the most serious cases of chronic high blood pressure, also known as hypertension.

The first procedure was performed in early November by cardiologists Dr. Micha Dorsch and Dr. Keysun Ranjbar, along with their multidisciplinary team members.

Research shows over-activity in the nerves along the renal arteries, the main blood supply to the kidneys, can lead to severe hypertension that responds poorly to conventional medications. Renal denervation is the process of using low-level radio frequency energy to deliberately neutralize selected nerves within the wall of the arteries of the kidneys to eliminate the root cause of the hypertension.

More than 500,000 Albertans have been diagnosed with hypertension, which has long been branded a silent killer. Individuals often show no symptoms even as internal damage is being done. With renal denervation, a single procedure can drastically reduce hypertension.

New research into gene therapy:

In the fall of 2012, AHS researchers launched the first gene therapy clinical trial in the world for Fabry disease, a rare inherited enzyme deficiency that shortens the lifespan of people who have it by as much as 40 years. People with Fabry disease have a change in a gene and can't make enough enzyme to break down a fatty substance called Gb3. The build-up of Gb3 can lead to problems in the kidneys, heart and brain.

The clinical trial was prompted by promising gene therapy results in mice performed in University Health Network in Toronto. Dr. Aneal Khan, a medical geneticist based at Alberta Children's Hospital, is leading the Calgary segment of the national project. Dr. Khan is affiliated with the University of Calgary's Alberta Children's Hospital Research Institute, which is a multi-disciplinary partnership of the University of Calgary, AHS and the Alberta Children's Hospital Foundation.

The project is being funded by the Canadian Institute of Health Research and the Kidney Foundation of Canada.

Health care locator:

A health care locator was launched on the AHS's website, and the AHS mobile application, available for iPhones/ iPads and Android devices. The tool allows Albertans to type in their postal code and search for the nearest facilities or services most appropriate for their specific health needs. Directions to facilities are provided using Google Map functionality. The health care locator is one of several tools and resources now available on the AHS app, which also includes real-time emergency wait times for Calgary and Edmonton-area hospitals and urgent care centres.

Job seekers via Facebook:

Job seekers can connect with a new career via AHS's Careers Facebook site. Facebook users can read career profiles and employee stories, watch videos, ask questions and share experiences with others interested in health care job opportunities. AHS and Apple magazine also have Facebook pages. ■

Summary of 2012-13 Performance Results

Alberta Health Services (AHS) is working to continually improve the quality of care we provide to Albertans. In all areas of the province, significant progress is being made toward building a patient-focused, quality health system that is accessible and sustainable for all Albertans. Over the course of the past year, we have undertaken many activities and monitored our progress every step of the way. The following summarizes the key initiatives which have helped us to advance our goals. The results overall indicate organizational improvement, and that many of the efforts that have been initiated during the earlier years of AHS are starting to show positive results. For more details on our achievements and performance measures, refer to the Appendix section of this report.

Assess the health needs of Albertans:

AHS is developing a consistent way to assess the health needs of individuals in rural areas and vulnerable and diverse communities. Over the past year, teams within the organization and external partners and stakeholders have worked together to reduce inequities and identify key targets for improvement in the health outcomes for these Albertans. In conjunction with Alberta Health, we are continuing to build the foundation needed for more robust health assessments, performance reporting. We are allocating resources to allow AHS to move forward in these areas in the years to come.

Determine priorities and allocate resources:

This past year involved extensive work to define the strategies and actions that will guide AHS in the coming years, and to determine how we will invest and reassess the funds used to support these strategies and actions. In collaboration with Alberta Health, AHS developed new strategic directions - bringing appropriate care to the community, establishing a partnership in health and achieving sustainability for the organization - and the *Alberta's Health System Outcomes and Measurement Framework*. These focused on improving health care across three dimensions: improving patient experience, improving health outcomes and improving value for money. These high-order dimensions supported our strategic directions. In addition to these important steps priority setting framework was established and utilized to support the Strategic Clinical Networks.

Ensure Access to Quality Care:

AHS continues to increase the number of **surgeries** performed. More joint replacement surgeries (11,330) have been performed this year. Zones continue to collaborate with the Alberta Bone and Joint Institute to address wait times, and ensure patients get home sooner with appropriate home care referrals. A pilot project to implement a standardized diagnosis-based priority system to book surgeries throughout the province was sponsored by the Surgery Clinical Network. The most dramatic improvement was seen in cataract surgery where wait times are 29.0 weeks this year from 37.3 weeks last year, a 22 per cent improvement. A number of initiatives reduced wait times for hip, knee, cataracts and other surgeries in 2012-13, and we anticipate continued improvement in the upcoming year as wait lists are reduced.

Improvements have been made to reduce wait times in **cancer care**. There has been significant improvement in the past two years, with "ready to treat to first radiation treatment" continuing to be better than target. While improvements have been made reducing wait times for "referral to first consult", targets have not yet been achieved.

Improvements continue for **emergency department** patients admitted and discharged within eight and four hours, respectively, in spite of significant increases in the numbers of patients seeking emergency care in the same period.

Despite this positive trend, AHS did not meet all of the targets in 2012-13. A series of system-wide initiatives have been implemented to continually improve Albertans' access to emergency care. These include adding new hospital beds, utilizing capacity protocols that improve patient flow during periods of high demand, and continuing to implement our discharge process - a standardized model for enhanced flow from acute care to home.

Strategic Clinical Networks (SCNs) are working to reshape health care, each network will work towards improving the patient experience, ensuring care is available when it's needed, putting strategies in place to keep Albertan's healthy, and providing Albertans with the best health care for generations to come. As a provincial health care system, AHS has the opportunity to learn from and share best practices across the province. We also have the opportunity to work together to develop new and innovative ways of doing things that can be shared province-wide.

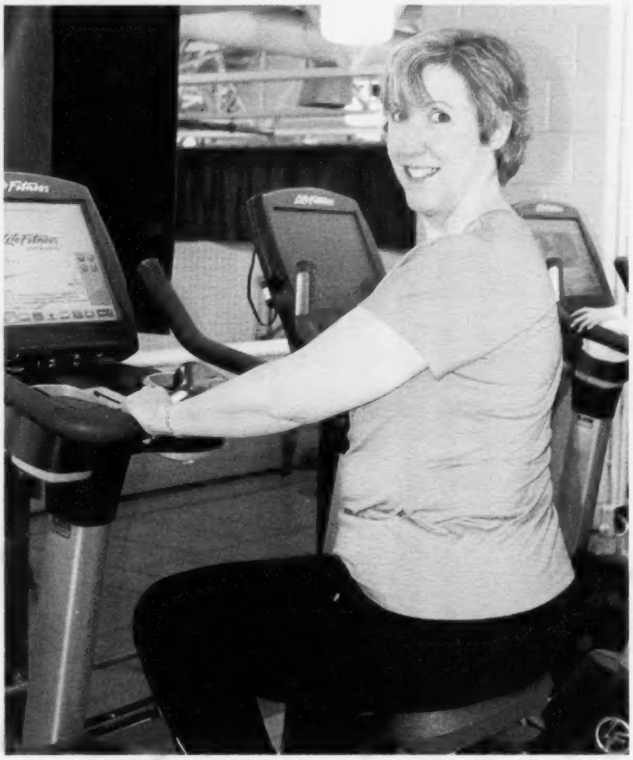
AHS continues to expand **seniors' living options** across the province, confirming our commitment to provide the right care in the right place. For those able and wanting to continue to live in their own homes, AHS has made significant investment in home care and other services and programs that keep people safe and healthy in their homes, including post discharge from hospital. AHS continues to support the province's seniors by adding continuing care beds. This year, AHS opened 877 new continuing care and palliative beds. This is part of an ongoing goal to open 1,000 new continuing care beds each year. In the last three years, AHS has opened 3,034 beds.

AHS continues to focus on strengthening access, quality and sustainability of **primary care services** to improve the health and wellness of all Albertans by: shifting emphasis from treating illness to creating health and wellness, helping individuals to be proactive about their own health, implementing team-based approaches to providing primary care through Primary Care Networks and Family Care Clinics, providing unlimited access to Health Link Alberta and www.myhealth.alberta.ca, working with other primary care providers, to help individuals manage chronic illness through patient education, exercise and self-management strategies, and integrating addiction and mental health support into primary care services throughout Alberta. Over the past year, significant work is ongoing to implement Alberta's Addiction and Mental Health Strategy.

Promote and protect the health of the population:

Health inequities exist in Alberta and are a growing concern. Despite universal access to health services and a generally high standard of living, there are considerable differences in health status among Albertans. These are linked to social and economic factors, notably income, education and employment. The consequences of not addressing health inequities are reflected in increased health spending and lost productivity. A coordinated effort is required to promote and protect the health of all Albertans and to address health inequities.

In collaboration with Alberta Health and other partners, numerous initiatives have been developed, implemented and strengthened in the areas of **population wellness, health promotion, screening programs, chronic disease prevention**, injury prevention, healthy development, addiction and mental health, environmental public health and Aboriginal health/reducing disparities and communicable disease control.



Meghan Charters is gaining the skills she needs to manage her Multiple Sclerosis symptoms and live successfully with her condition thanks to the AHS Living Well with a Chronic Condition program in Calgary.

In addition to improving quality of life, these initiatives will help to increase life expectancy and reduce potential years of life lost. Actions are focused on increasing immunization, preventing chronic disease, supporting healthy physical and social environments, healthy living and healthy weights. We are building and delivering appropriate services and health promotion initiatives with, and for, diverse and vulnerable populations.

Integration of Services and Support Functions:

Integration is also necessary for those areas of AHS that support delivery of services directly to individuals and their families. In **building one health system** for all Albertans, the health service workforce and workplace, and the foundational work necessary to integrate business support services on a provincial basis, are key components that will allow us to deliver quality services.

Ensuring the AHS **workforce** is supported, and their skills are utilized in the most appropriate and efficient way is of utmost importance to AHS. Continued efforts have resulted in recruiting the vast majority of RN graduates. The ratio of full-time equivalent to headcount showed significant improvement and has surpassed the 2012-13 target.

AHS teams developed local engagement plans to further bolster engagement from the ground up. Occupational injury and illness reduction plans are focusing on mitigating workplace hazards and building employee resilience to cope with workplace demands.

Numerous **Information Technology** (IT) initiatives continue to be implemented on a province-wide basis. Through consolidation of IT systems and infrastructure, savings of over $13.3 million was achieved since 2010-11. Investment in technology is critical to enable a high- functioning, safe, efficient health system. This will continue to be advanced in a coordinated and prioritized manner.

Exciting **health research** is taking place in this province that is making a difference in the lives of Albertans today and changing the course of how illness and disease will be treated in the future. We are also fortunate to have unprecedented access to new technology in this province. Currently, 40 Health Technology Assessment projects are in process in varying stages.

Completed research projects include corneal cross-linking, portable prothromin time systems, TMJ (Temporomandibular Joint), arthroplasty, hysteroscopiec sterilization, transcutaneous bilirubinometry program for neonatal jaundice and BioMimetic bone augmentation.

Patient safety remained a high priority with a variety of initiatives being implemented. In particular, much work is underway to share best practices across the province and develop standardized provincial approaches. A new clinical policy has also been developed around hand hygiene. This policy has been created to standardize expectations and strengthen hand hygiene practices across the province. The use of good infection prevention and control practices helps prevent infections from occurring while patients are in health care facilities. Supports are available to health care workers to manage the care and placement of patients with known or suspected diseases and are applicable to acute care emergency, inpatient, ambulatory, medical, surgical and outpatient settings. AHS also provided recommendations and resources to help prevent the spread of Influenza.

Pat Laporte and his wife, Leah, cuddle their newborn son, Liam. Grateful for the the fast action of AHS paramedics and hospital staff, Pat says the happy ending to his wife's complex delivery was the result of the work of their health care teams. He says "Keep doing what you're doing!"

Patient satisfaction has slightly improved over the past two years, according to the 2012 Health Quality Council of Alberta (HQCA) survey. Overall, 64 per cent of Albertans indicated they were satisfied with the health care services they received, compared to 62 per cent in the previous HQCA patient satisfaction survey from 2010. The survey also shows more Albertans believe access has improved since 2010 for a number of health care services, including family doctors, specialists, diagnostic imaging, magnetic resonance imaging (MRIs) and walk-in clinics.

Everything we do at AHS is about improving the health of Albertans. **Community input and engagement** furthers our ability to provide quality, patient-focused health care that is accessible and sustainable. Through community feedback we can better address the health needs of communities. Patients, families and every Albertan are important to us. Advisory Councils have been appointed by AHS to provide guidance and recommendations on service delivery, program design and evaluation to ensure appropriate and innovative health service delivery in Alberta. Our Advisory Councils include the following: Health Advisory Councils, Provincial Advisory Council on Addiction & Mental Health and Provincial Advisory Council on Cancer.

AHS was awarded *"**Accreditation** with Report"* by Accreditation Canada. AHS met 94 per cent of the high priority standards criteria and 89 per cent of the total criteria. This is a great achievement for a large organization. There continues to be work to be done to fully meet or exceed the criteria. In October, 2012, 21 Accreditation Canada surveyors visited 95 AHS sites across the province, talking with staff and physicians, patients and families, to evaluate how AHS compares with nationally-established health care performance standards.

In Summary: We are starting to notice the rewards of time, effort and money invested by AHS in improving our province's health system and we can celebrate some important achievements. In 2012-13, we:

- partnered in expanding new primary care models, including 40 Primary Care Networks, three Family Care Clinics and seven Urgent Care Centres, to give Albertans more direct access to health care services,
- worked to implement the Alberta government strategy to create a more seamless system for addictions and mental health,
- opened over 3,000 new continuing care spaces since 2010, as part of a strategy to increase access and care choices for seniors,
- added capacity with the opening of the South Health Campus in the Calgary Zone and the Kaye Edmonton Clinic in the Edmonton Zone - improving patient care and access to out-patient services,
- cut wait times for key procedures – reduced the wait time for cataract procedures by eight days, hip replacements by 3.5 days and knee replacements by seven days since 2011-12,
- posted "real time" Emergency Department wait times for urban hospitals in Calgary and Edmonton - the first in Canada to do so,
- provided improved access to stroke care resulting in 23 per cent fewer emergency/hospital visits and over 25 per cent fewer in-hospital deaths from stroke.

AHS has built a health care foundation in this province that will provide Albertans with better access to high-quality care and reduce wait times for surgeries, cancer treatment and continuing care. We have been working to create a patient-focused health system where decisions are made closest to where care is provided. We are going to continue to be very thoughtful about where we invest health care dollars because this has a direct impact on what we can do to improve the health of Albertans.

The path ahead will have challenges, but we will work with Albertans, our staff, physicians, volunteers and government to build a sustainable quality health system for all Albertans and their families. The new AHS 2013-2016 Health Plan and Business Plan were built on what was important to Albertans related to health care services. It's about the needs of Albertans right now and the challenges we face with a growing population and a tighter financial future. These plans are designed to take us from here, in 2013, to where we need to be, in 2016 and beyond. ■

Financial Statements

Financial Statement Discussion & Analysis

Consolidated Financial Statements

Financial Statement Discussion and Analysis

For the year ended March 31, 2013

(in millions of dollars)

Purpose

This Financial Statement Discussion and Analysis (FSD&A) is provided to enable readers to assess Alberta Health Services' (AHS's) results of operations and financial condition for the year ended March 31, 2013 compared to budget and to the preceding year. In particular, the FSD&A reports to stakeholders on how financial resources are being managed to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans.

This FSD&A has been prepared by management and should be read in conjunction with the March 31, 2013 audited consolidated financial statements, notes and schedules. The consolidated financial statements are prepared in accordance with Public Sector Accounting Standards and Financial Directives issued by Alberta Health (AH). All amounts are in millions of dollars unless otherwise specified.

The conversion from Canadian Generally Accepted Accounting Principles (CGAAP) to Public Sector Accounting Standards (PSAS) was completed in fiscal 2013. AHS has adopted the new accounting framework effective April 1, 2012. As a result, terminology, presentation and prior year amounts have changed from the 2011-12 consolidated financial statements.

AHS financial statements are prepared on a consolidated basis and include the following:

- 3 wholly owned subsidiaries: Calgary Laboratory Services Ltd., Capital Care Group Inc., and Carewest;
- 28 controlled foundations
- 50% interest in the 40 Primary Care Networks (PCNs), 50% interest in the Northern Alberta Clinical Trials Centre joint venture and 30% interest in the HUTV limited partnership; and
- Provincial Health Authorities of Alberta Liability and Property and Insurance Plan (LPIP) and the Queen Elizabeth II Hospital Child Care Centre.

Additional information about AHS including financial reports from prior periods is available on the AHS website at **www.albertahealthservices.ca**.

Overview of 2012-13

The following table summarizes the Consolidated Statement of Operations:

STATEMENT OF OPERATIONS	BUDGET 2013	ACTUAL 2013	VARIANCE	ACTUAL 2012	INCREASE (DECREASE)
Revenue	$12,729	$12,674	$(55)	$11,834	$840
Expenses	12,737	12,568	169	11,747	821
Operating surplus (deficit)	**$(8)**	**$106**	**$114**	**$87**	**$19**

2012-13 Highlights

2012-13 key strategic areas highlighted through "Our Stories" included:

- Be healthy, stay healthy
- Strengthen primary health care
- Improve access and reduce wait times
- Provide more choice for continuing care
- Build one health system

2012-13 saw the realization of some long-established commitments, including:

- Opening of East Edmonton Urgent Care Centre
- Opening of Kaye Edmonton Clinic
- Opening of South Health Campus in Calgary
- Opening of 877 new continuing care and palliative beds
- Implementation of key components of the Addictions and Mental Health strategy
- Opening of the first 3 Family Care Clinics
- Implementation of various Health Quality Council of Alberta (HQCA) recommendations

The AHS operating surplus for the year ended March 31, 2013 is $106 compared to a budget of $(8). The $114 positive variance is primarily due to lower than budgeted expenses resulting from timing variances in the implementation of new and on-going initiatives (including various Addictions & Mental Health programs, and the Continuing Care Capacity Plan), opening of new facilities (particularly South Health Campus and the Kaye Edmonton Clinic) and recruiting physician and staff positions.

There continues to be a focus on administration expense and during 2012-13 net administration expense has been presented in a note to align with the Canadian Institute of Health Information definition as detailed in the Canadian Hospitals Reporting Project. Net administration expense includes:

- General administration – corporate and other ongoing internal support functions,
- Human resources,
- Finance,
- Communications (previously reported in support services),
- Administration expense of contracted health service providers, less
- External recoveries for administration provided to others.

AHS's net administration expense for fiscal 2012-13 was $439, representing 3.6% of adjusted total expenses of $12,329, which is net of recoveries, inclusive of bad debt expense and exclusive of expenses related to supporting foundations.

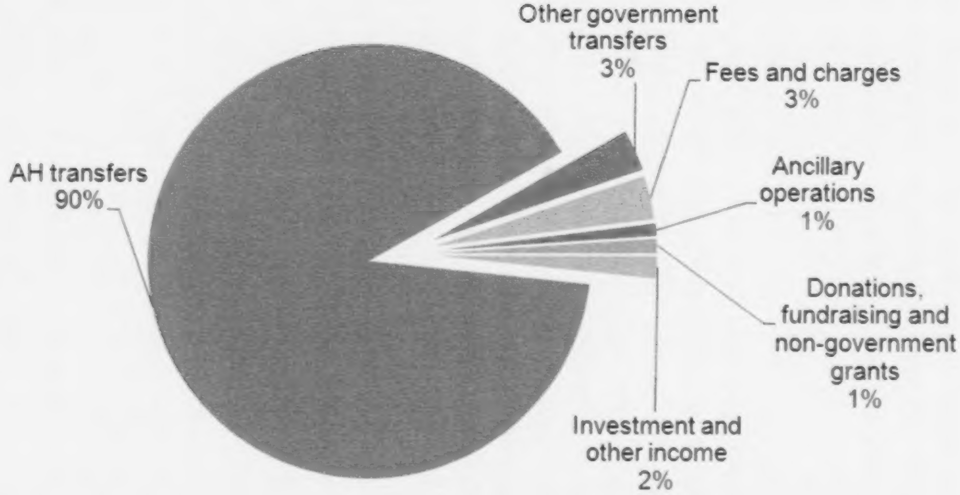
AHS's annual expenditures of $12,568 equates to approximately $34 per day, hence the operating surplus of $106 represents approximately 3.1 days of expenses, or 0.8% of total expenses, and the unrestricted net assets of $83 represents approximately 2.4 days of expenses, or 0.7% of total expenses.

Accumulated operating surplus is made up as follows:

ACCUMULATED OPERATING SURPLUS	ACTUAL 2013	ACTUAL 2012	INCREASE (DECREASE)
Unrestricted net assets	$83	$(3)	$86
Reserves for future purposes	79	99	(20)
Net assets invested in tangible capital assets	916	876	40
Accumulated operating surplus	**$1,078**	**$972**	**$106**

Statement of Operations

Revenue



Total 2013 revenues increased by $840 or 7.1% from 2012 and were lower than budgeted amounts by $55. The overall increase in revenue was primarily due to increased base operating funding from AH, who is AHS's primary source of funding. AH funding coverage indicator is 91% (2012 – 90%), representing the percent of expenses being funded by AH in 2013.

REVENUE	BUDGET 2013	ACTUAL 2013	VARIANCE	ACTUAL 2012	INCREASE (DECREASE)
Alberta Health transfers	$11,472	$11,397	$(75)	$10,590	$807
Other government transfers	362	393	31	346	47
Fees and charges	439	412	(27)	416	(4)
Ancillary operations	127	118	(9)	122	(4)
Donations, fundraising and non-government grants	129	144	15	146	(2)
Investment and other income	200	210	10	214	(4)
Total revenue	**$12,729**	**$12,674**	**$(55)**	**$11,834**	**$840**

Significant variances are explained as follows:

- **Alberta Health Transfers** comprises all AH grants – unrestricted, restricted, operating and capital. Unrestricted funding is the main source of operating funding to provide health care services to the population of Alberta. Restricted funding is revenue that can only be used for specific projects and is recognized when the terms of the grant are met.

ALBERTA HEALTH TRANSFERS	BUDGET 2013	ACTUAL 2013	VARIANCE	ACTUAL 2012	INCREASE (DECREASE)
Base operating grants	$10,212	$10,214	$2	$9,634	$580
Other operating grants	1,164	1,076	(88)	835	241
Capital grants	96	107	11	121	(14)
Total AH transfers	**$11,472**	**$11,397**	**$(75)**	**$10,590**	**$807**

AH transfers resulted in a negative variance of $75 or 0.7% as compared to budgeted levels due mainly to delays in the recognition of restricted funding. There were delays in the implementation of various initiatives funded by restricted AH grants, including the South Health Campus due to changes in the implementation schedule, Kaye Edmonton Clinic, Addiction & Mental Health initiatives and other smaller initiatives funded by AH. The overall negative variance was partially offset by some additional grant revenue and higher activity in various programs.

AH transfers increased by $807 in 2013 compared to 2012 due to the increase in base operating funding of 6% or $580, additional funding for the incremental operating costs of new health facilities, particularly South Health Campus and Kaye Edmonton Clinic, additional funding for Home Care initiatives, and incremental amortization on current year additions. The overall increase in AH transfers was partially offset by a decrease in capital grants recognized due to various capital assets that became fully amortized.

- **Other government transfers** are ongoing and one-time transfers for operating and capital purposes from federal, provincial (other than AH) and municipal governments.

  Other government transfers amounted to $393 compared to a budget of $362 resulting in a positive variance of $31 or 8.6% mainly due to unbudgeted Alberta Infrastructure (AI) grants recognized for the Covenant Health continuing care beds project, unbudgeted University payments for salary and benefits of faculty jointly appointed with AHS, increased revenue recognized from AI grants for various infrastructure maintenance projects and minor equipment purchases for major capital projects.

  The increase in other government transfers of $47 as compared to the prior year is primarily due to the increase in AI funded minor equipment related to the clinical commissioning of the South Health Campus and Kaye Edmonton Clinic, as well as an increase in capital grants recognized due to the substantial completion of the South Health Campus, Kaye Edmonton Clinic and various rural health facilities.

- **Fees and charges** consist of patient revenue for health services at rates set by the Minister and collected by AHS from individuals, Workers Compensation Board (WCB), federal and provincial governments, and other responsible parties such as Alberta Blue Cross and insurance companies.

  Fees and charges revenue amounted to $412 compared to a budget of $439 resulting in a negative variance of $27 or 6.2%, which is primarily due to an increase in bad debts expense related to self-pay accounts, including out-of-country patient billings and increasing outstanding accounts related to long-term care accommodation fees and inter-provincial patient billings. Further contributing to the negative variance is decreased patient fees and charges from other provinces, LTC residents and WCB. The overall negative variance was partially offset by an increase in patient fees and charges primarily from out-of-country billings and the federal government.

  Fees and charges revenue decreased by $4, as compared to the prior year.

- **Ancillary operations** are the sale of goods and services that are unrelated to the direct provision of health services and include parking, non-patient food services, the sale of goods and services and rental operations.

  Ancillary operations revenue amounted to $118 compared to a budget of $127 resulting in a negative variance of $9 or 7.1% mainly due to lower equipment rental revenue and lower inventory sales in certain facilities.

  Ancillary operations decreased by $4, as compared to the prior year.

- **Donations, fundraising and non-government grants** comprise revenue that is unrestricted, restricted, operating and capital. Restricted amounts received are recognized when the restrictions are met.

  Donations, fundraising and non-government grants revenue amounted to $144 compared to a budget of $129 resulting in a positive variance of $15 or 11.6%, which is mainly due to unbudgeted revenue recognized for minor equipment purchases funded by various foundations, and increased donations and non-government grants revenue recognized by the Calgary Health Trust.

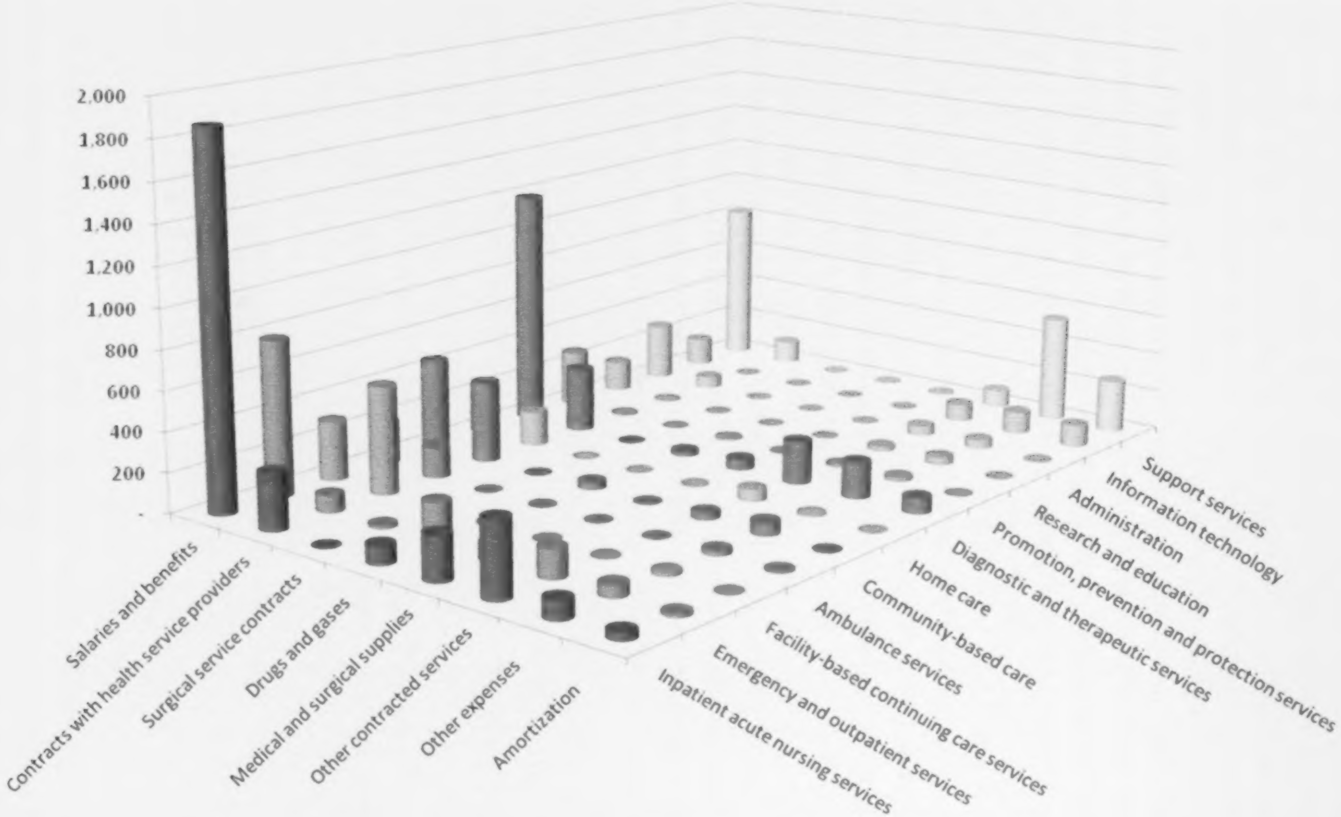
  Donations, fundraising and non-government grants decreased by $2, as compared to the prior year.

- **Investment and other income** is comprised of interest income, dividends, net realized gains and losses on disposal of investments, and recoveries from external sources other than ancillary operations. Included are revenue from third parties, such as drug and medical supply companies, and universities.

  Investment and other income amounted to $210 compared to a budget of $200 resulting in a positive variance of $10 or 5.0% mainly due to unbudgeted recoveries and increased purchase incentive rebates, partially offset by the decrease in investment income due to the liquidation of some portfolio investments to accommodate cash demands associated with union contract settlements and various salary and pension adjustments, and lower than anticipated external recoveries for services provided to external entities.

  Investment and other income decreased by $4, as compared to the prior year.

Expenses – By Function And Object



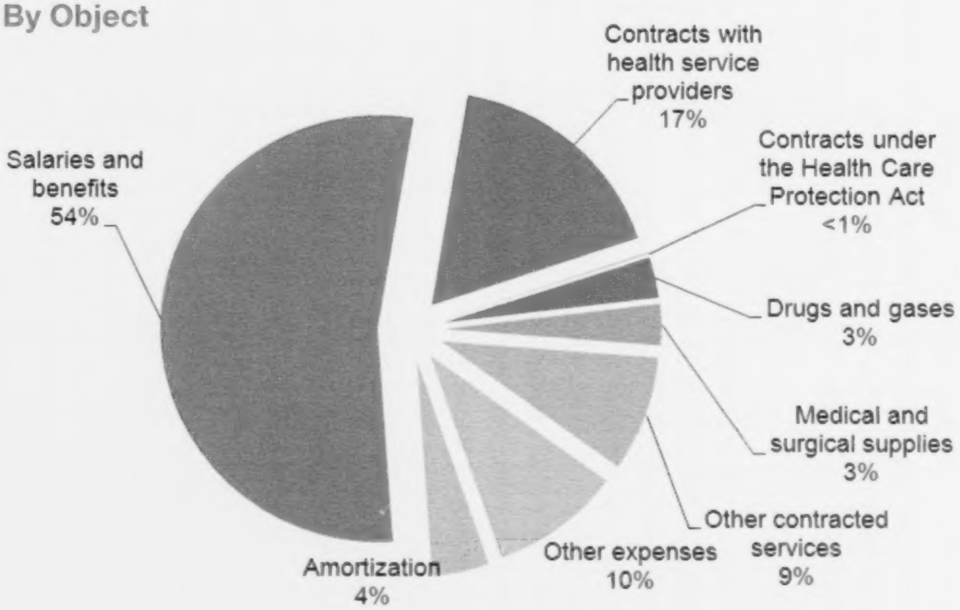
Alberta Health Services reviews and reports operating expenditures by function and by object in order to fully understand and present the results of current operations, strategic priorities and new investments. Operating expenditures increased to $12,568 in 2012-13, representing 7.0% growth from the prior year. Expenditure growth includes support for continuing existing operations, support for strategic priorities and new investments, and support for the operating requirements of new facilities. The graph above illustrates the most significant areas of operational spending, by function and related objects. A significant portion of the program expenses occurs in inpatient acute nursing services (within which salaries and benefits and other contracted services are the highest cost objects), emergency and outpatient services (within which salaries and benefits are the highest cost objects), facility-based and continuing care services (within which contracts with health service providers is the highest cost object), community-based care (within which contracts with health service providers is the highest cost object), diagnostic and therapeutic services (within which salaries and benefits and other contracted services are the highest cost objects) and support services (within which salaries and benefits, other expenses and amortization are the highest cost objects).

2012-13 Budget Restatement

During fiscal 2012-13, the budget was restated in order to reflect the transition to Public Sector Accounting Standards (discussed in the "Change in Accounting Framework" section below). Further affecting the budget are the budget system reclassifications and the realization of key budget assumptions, which are discussed within the variance analysis of the expenses below.

The 2012-13 budget was prepared at the financial statement level and approved by the Board in May 2012. After the new budget was approved, AHS implemented a new AHS budgeting and planning system. AHS used the new system to rebuild the budget at the cost centre level, using the same assumptions as the original budget. This implementation has led to improved reporting capabilities and increased accuracy of its detailed budget, allowing for greater accountability and transparency. The rebuilt budget was used for management accountability reporting during 2012-13 and is accounted for in the variance analysis to follow. The original and rebuilt budgets have the same total revenue and expenses and the same functional assumptions. The resulting differences are referred to as "budget system reclassifications", and cannot be attributed to any change in assumption, program or specific initiative.

Expenses – By Object



The distribution of expenses by object has remained consistent with prior years, with salaries and benefits making up more than half of total expenses. While AHS continues to focus on priority areas such as reducing wait times in emergency departments, expanding continuing care operations and improving access to high-demand surgeries, expenses continue to be driven by salaries, benefits, and contracts with health service providers, whose costs would also be driven by salaries and benefits.

During 2012-13, the organization continued to experience challenges in recruiting physicians and staff at the pace anticipated within the 2012-13 operating budget, resulting in implementation delays of certain priority initiatives including the continuing care capacity plan, various Addictions & Mental Health initiatives and HQCA initiatives. The overall positive variance was partially offset by increased patient volumes, activity and infrastructure resulting in increased drugs and gases, medical and surgical supplies, clinical supplies, buildings and ground expense. The addition of new sites resulted in increased lease, occupancy and maintenance costs.

EXPENSES	BUDGET 2013	ACTUAL 2013	VARIANCE	ACTUAL 2012	INCREASE (DECREASE)
Salaries and benefits	$6,851	$6,753	$98	$6,161	$592
Contracts with health service providers	2,265	2,166	99	2,018	148
Contracts under the Health care Protection Act	21	17	4	18	(1)
Drugs and gases	386	388	(2)	388	-
Medical and surgical supplies	354	392	(38)	360	32
Other contracted services	1,148	1,099	49	1,056	43
Other expenses	1,191	1,220	(29)	1,271	(51)
Amortization	521	533	(12)	475	58
Total expenses	**$12,737**	**$12,568**	**$169**	**$11,747**	**$821**

Significant variances and changes are explained as follows:

- **Salaries and benefits** is comprised of compensation for worked hours, vacation and sick leave, other cash benefits (which includes overtime), employee benefit contributions made on behalf of employees, and severance.

  Salaries and benefits expenses amounted to $6,753 compared to a budget of $6,851 resulting in a positive variance of $98 or 1.4%. Included in this variance is a positive $7 budget system reclassification, as well as unused contingency of $27. The remaining $64 positive variance is mainly due to vacant positions throughout the organization stemming from hard-to-recruit positions, regular revolving vacancies and timing of recruitment. There have been delayed initiatives relative to when budgeted, leading to delayed hiring, particularly with respect to the timing of the opening of the South Health Campus, as well as vacancies causing delays in initiatives. There was also a credit recognized from net surpluses held by benefit plans. The overall positive variance is partially offset by increased activity in the zones (leading to increased overtime), overtime due to vacancies, as well as unfunded anticipatory hires for the South Health Campus funded from internal reserves and additional compensation costs for the South Health Campus.

  There is an increase of $592 over prior year mainly due to the increased number of employees, salary rates and benefit increases (including increases under collective agreements and Local Authorities Pension Plan, impacted by the increase in employees, hours, rates and retro payments), compression payment increases, increased overtime expenses and inflation. New and existing positions were filled to manage increased activity and capacity, particularly related to the opening of South Health Campus and Kaye Edmonton Clinic. Further increased salary and benefit costs were incurred in order to undertake increasing HQCA initiatives and other strategic priority initiatives. Although the number of employees increased compared to the prior year, vacancies persisted throughout the organization increasing capacity pressures and resulting in the need for increased overtime, call backs and casual relief. The overall increase in salaries and benefits was partially offset by various savings initiatives and the expiry of various grant-funded initiatives resulting in decreased salary and benefits costs, as well as an increase in net surpluses held by benefit plans.

- **Contracts with health service providers** include voluntary and private health service providers with whom AHS contracts for health services.Contracts with health service providers expenses amounted to $2,166 compared to a budget of $2,265 resulting in a positive variance of $99 or 4.4%. Included in this variance is a positive $34 budget system reclassification, as well as unused contingency of $14.

The remaining $51 positive variance is mainly due to timing variances associated with the implementation of various budgeted initiatives, including various Addictions and Mental Health programs (e.g. Community Treatment Orders, Provincial Family Violence Program, Mental Health Capacity and Life Skills Training Substance Abuse Prevention Program), Alberta Cancer Prevention Legacy Fund, HQCA initiatives and the Continuing Care Capacity Plan (i.e. timing of opening new seniors health facilities, facilities not operating at full capacity and the timing of beds opened). The overall positive variance was partially offset by significant increases in home care vendor hours.

There is an increase of $148 over prior year due to the addition of 867 continuing care beds, new supportive living sites, inflation, which lead to contract rate increases, increased activity particularly with respect to home care hours and further spending on various priority initiatives. The overall increase was partially offset by the expiry of seniors health grants in the prior year and various savings initiatives achieved.

- **Contracts under the Health Care Protection Act** relates to contracts with surgical facilities pursuant to the Health Care Protection Act which is about ensuring quality, while ensuring more efficient delivery of publically funded services by allowing contracting out to private surgical facilities.

  Contracts under the Health Care Protection Act amounted to $17 compared to a budget of $21 resulting in a positive variance of $4 or 19.0%. Included in this variance is a positive $2 budget system reclassification, resulting in a net variance of $2.

  There is a decrease of $1 over prior year.

- **Drugs and gases** expenses include all drugs used by AHS, including medicines, certain chemicals, anaesthetic gas, oxygen and other medical gases used for patient treatment, but excluding vaccines paid for by AH. Drugs used for other than patient treatment such as diagnostic reagents are not considered part of this category, but rather included in other expenses.

  Drugs and gases expenses amounted to $388 compared to a budget of $386 resulting in a negative variance of $2 or 0.5%. Included in this variance is a positive $35 budget system reclassification. The remaining negative $37 variance is mainly due to increasing drug volumes and costs, partially offset by delays in the opening of the South Health Campus.

  There is no change compared to the prior year.

- **Medical and surgical supplies** include prostheses, instruments used in surgical procedures and in treating and examining patients, sutures and other supplies.

  Medical and surgical supplies expenses amounted to $392 compared to a budget of $354 resulting in a negative variance of $38 or 10.7%. Included in this variance is a negative $21 budget system reclassification, as well as unused contingency of $2. The remaining $19 negative variance is mainly due to increased activity within the zones related to operating rooms, increased surgical volumes, cardiac, renal, home care, inpatients and emergency department visits.

  There is an increase of $32 over the prior year mainly due to inflation and increased activity, including emergency visits, surgical procedures, hip and knee replacements, cardiac and other highly specialized procedures. Further contributing to the increased costs is the opening of the South Health Campus, as well as the implementation of HQCA recommendations and other strategic priority initiatives.

- **Other contracted services** are payments to those under contract that are not considered to be employees. This category includes payments to physicians for referred-out services and purchased services.

  Other contracted services expenses amounted to $1,099 compared to a budget of $1,148 resulting in a positive variance of $49 or 4.3%. Included in this variance is a positive $29 budget system reclassification, as well as unused contingency of $3. The remaining positive $17 variance is mainly due to physician recruitment issues resulting in vacancies; impact of the compensation settlement between the Alberta Government and the Alberta Medical Association, timing variances associated with the implementation of various budgeted initiatives including the opening of South Health Campus, Syphilis Prevention campaign, Pandemic Supplies, Addictions and Mental Health Initiatives and Physician / Specialist on-call activity. The overall positive variance is partially offset by increased activity in various Physician Alternative Relationship Plans, increased Infrastructure Maintenance Program (IMP) spending, as well as increased use of contracted operators to cover vacancies.

  There is an increase of $43 from prior year due to increased activity from the prior year, resulting in increased contracts and increased use of contracted services in certain areas due to vacancies within the organization. Increased costs were also incurred with the opening of various new facilities, including South Health Campus and Kaye Edmonton Clinic, as well as new initiatives taking place in fiscal 2013.

- **Other expenses** relate to those not classified elsewhere.

  Other Expenses amounted to $1,220 compared to a budget of $1,191 resulting in a negative variance of $29 or 2.4%. Included in this variance is a negative $86 budget system reclassification, as well as unused contingency of $7. The remaining positive $50 variance is mainly due to delays in various initiatives, including the delayed scheduled opening of South Health Campus and various savings initiatives, as well as savings related to natural gas rates and the achievement of various savings initiatives. The overall positive variance is partially offset by increased building and ground service contracts, various supplies expenses due to the increased operating activity levels and increased IMP costs due to increased project completions.

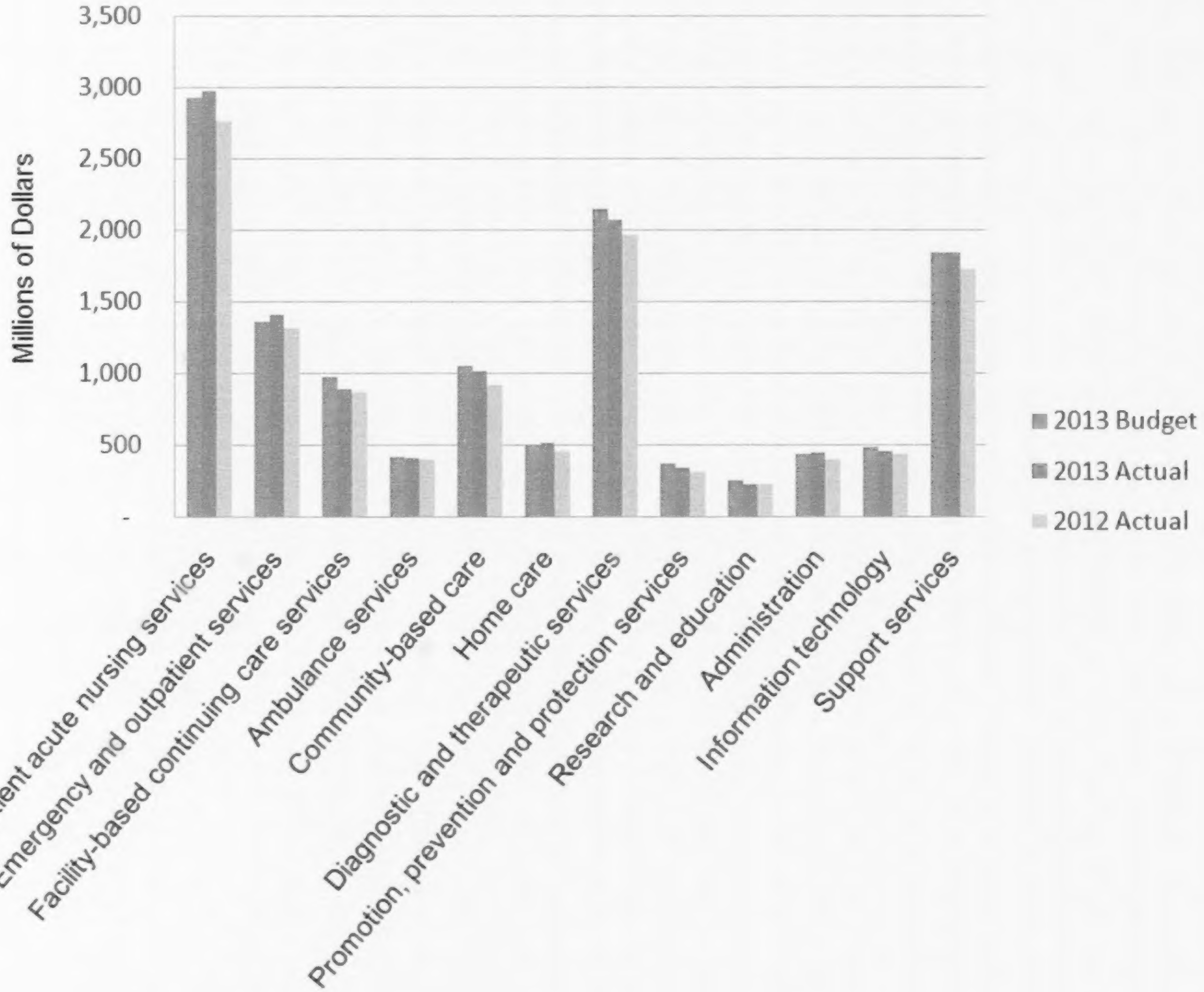
  There is a decrease of $51 over the prior year mainly due to a decrease in minor equipment purchases, office supplies purchases, and professional development expenses. Further contributing to the overall decrease is the prior year top-up payment required to increase the insurance provision for liabilities incurred but not yet reported as per the actuarial report, which was not required in the current year. The overall decrease was partially offset by increased expenses due to the opening of various new sites, including the South Health Campus and Kaye Edmonton Clinic, interest on long-term debt due to the related opening of parkades, increased leasing costs, building and service contract costs and an increase in the number of IMP projects completed.

- **Amortization expenses** relates to the periodic charges to expense representing the estimated portion of the cost of the respective physical asset that expired through use and age during the period.

  Amortization amounted to $533 compared to a budget of $521 resulting in a negative variance of $12 or 2.3%, mainly due to an increase in capital asset additions and adjustments to expected completion costs of projects; partially offset by delays in project capitalizations, such as the South Health Campus.

  There is an increase of $58 over the prior year mainly relating to the substantial completion and capitalization of certain large facilities, including South Health Campus and Kaye Edmonton Clinic, as well as various other new capitalizatons.

Expenses – By Function



Total expenses in 2012-13 increased by 7.0% from 2011-12 and were lower than budgeted amounts by 1.3%. The overall increase in expenses was primarily due to increased salary and benefit costs, increased contract costs, inflation and increased patient volumes. AHS's distribution of expenses has remained consistent with the previous year, with inpatient acute nursing services and diagnostic and therapeutic expenses making up 40% of total expenses. While almost all areas experienced an increase from the prior year, the largest relative increase was in home care.

EXPENSES	BUDGET 2013	ACTUAL 2013	VARIANCE	ACTUAL 2012	INCREASE (DECREASE)
Inpatient acute nursing services	$2,923	$2,972	$(49)	$2,761	$211
Emergency and other outpatient services	1,356	1,407	(51)	1,314	93
Facility-based continuing care services	971	887	84	867	20
Ambulance services	415	409	6	395	14
Community-based care	1,054	1,007	47	914	93
Home care	496	507	(11)	453	54
Diagnostic and therapeutic services	2,148	2,075	73	1,961	114
Promotion, prevention and protection services	368	337	31	311	26
Research and education	249	225	24	218	7
Administration	436	444	(8)	397	47
Information technology	480	455	25	435	20
Support services	1,841	1,843	(2)	1,721	122
Total expenses	**$12,737**	**$12,568**	**$169**	**$11,747**	**$821**

Significant variances are explained as follows:

- **Inpatient acute nursing services** are comprised predominantly of nursing units, including medical, surgical, intensive care, obstetrics, paediatrics and mental health. This category also includes operating and recovery rooms.

  Inpatient acute nursing services amounted to $2,972 compared to a budget of $2,923 resulting in a negative variance of $49 or 1.7%. Included in this variance is a positive $51 budget system reclassification, as well as unused contingency of $4. The remaining $104 negative variance is mainly due to increased activity levels, including increased operations, cardiac patients and increased patient days. Increased activity levels have resulted in increased salaries, benefits, medical and surgical supply costs. Increased costs were also incurred related to the increased use of overtime, as well as the use of agency nurses to fill vacancies and significant pre-hires and unfunded anticipatory hires used to address the opening of the South Health Campus. The overall increase in costs were partially offset by vacancies and delayed spending related to the phased-in opening of the South Health Campus, as well as other delayed initiatives, including HQCA, Medical Reconciliation Project and care transformation projects.

  There is an increase of $211 over prior year mainly due to increased activity (including additional hospital beds, surgical cases, labour & delivery, and hip & knee cases), inflationary increases in both labour and supplies, increased number of employees, and increased overtime and relief costs. The opening of the South Health Campus further contributed to a significant portion of the overall increase, particularly with respect to salaries and benefits, and medical and surgical supplies. The overall increase was partially offset by achieved savings initiatives and vacancies.

- **Emergency and other outpatient services** are comprised primarily of emergency, day/night care, clinics, day surgery, and contracted surgical services.

Emergency and other outpatient services amounted to $1,407 compared to a budget of $1,356 resulting in a negative variance of $51 or 3.8%. Included in this variance is a negative $58 budget system reclassification, as well as unused contingency of $16. The remaining negative variance of $9 is mainly due to increased activity levels, particularly within various zone emergency departments, as well as costs associated with unfunded anticipatory hires for the opening of the South Health Campus. The overall negative variance was partially offset by vacancies and delays in the opening of the South Health Campus.

There is an increase of $93 over prior year due to inflation, salary rate increases, addition of new employees, activity increases, particularly in emergency and clinic visits, renal runs and midwifery. Further increased costs were incurred with the opening of South Health Campus, particularly in salaries and benefits. The overall increase was partially offset by the achievement of targeted savings initiatives.

- **Facility-based continuing care services** are comprised of long-term care including chronic and psychiatric care operated by AHS and contracted providers.

Facility-based continuing care services amounted to $887 compared to a budget of $971 resulting in a positive variance of $84 or 8.7%. Included in this variance is a positive $91 budget system reclassification, as well as unused contingency of $2. The remaining negative variance of $9 is mainly due to increased use of overtime, agency nurses used to fill vacancies and unachieved savings initiatives, partially offset by delayed initiatives, particularly HQCA.

There is an increase of $20 over the prior year due to increased activity, increased costs due to contract inflation, and increased costs related to new HQCA initiatives.

- **Ambulance services** are comprised of EMS ambulance, patient transport, and EMS central dispatch.

Ambulance Services amounted to $409 compared to a budget of $415 resulting in a positive variance of $6 or 1.4%. Included in this variance is positive $11 budget system reclassification, as well as overspent contingency of $17. The remaining variance of positive $12 is mainly due to centrally-held funding for the settlement of ground contracts that have not yet been finalized, as well as vacancies and various savings initiatives. The overall positive variance is partially offset by increased use of casual staff and overtime due to vacancies and increased call volumes.

There is an increase of $14 over prior year mainly due to inflation, rate increases, additional employees recruited to fill vacancies and increased activity. The overall increase in costs was partially offset by reduced overtime.

- **Community-based care** is comprised primarily of supportive living, and palliative and hospice care. This category also consists of community programs; primary care networks (PCNs), urgent care centres, and community mental health.

Community-based care amounted to $1,007 compared to a budget of $1,054 resulting in a positive variance of $47 or 4.5%. Included in this variance is a negative $37 budget system reclassification, as well as overspent contingency of $13. The remaining positive variance of $97 is mainly due to vacancies and timing variances associated with the implementation of various budgeted initiatives, including the opening of new seniors' health facilities, facilities not operating at full capacity and the timing of beds opened under the Continuing Care Capacity Plan. Further delayed initiatives include various Addictions and Mental Health programs (including Community Treatment Orders, Provincial Family Violence Program, Safe Communities and Life Skills Training Substance Abuse Prevention Program) and various HQCA initiatives.

There is an increase of $93 over prior year mainly due to the opening of new beds and supportive living spaces in fiscal 2013 and the annualized impact of fiscal 2012 openings, contract inflation increases and increased activity in various initiatives including Safe Communities, family care clinics, HQCA and Access Improvement Measures, resulting in an increase in salaries and benefits and contract costs.

- **Home care** is comprised of home nursing and support.

  Home care amounted to $507 compared to a budget of $496 resulting in a negative variance of $11 or 2.2%. Included in this variance is a positive $16 budget system reclassification, as well as unused contingency of $1. The remaining negative variance of $28 is mainly due to an increase in home care activity. The increased activity has also lead to increased overtime and use of relief staff. The overall negative variance is partially offset by vacancies.

  There is an increase of $54 over prior year mainly due to inflation and a significant increase in home care activity, both in volume and rates. There were also increased salary and benefits costs as a result of new hires and rate increases, as well as increased costs related to new initiatives.

- **Diagnostic and therapeutic services** is comprised primarily of clinical lab (both in the community and acute), diagnostic imaging, pharmacy, acute and therapeutic services such as physiotherapy, occupational therapy, respiratory therapy and speech language pathology.

  Diagnostic and therapeutic services amounted to $2,075 compared to a budget of $2,148 resulting in a positive variance of $73 or 3.4%. Included in this variance is a positive $2 budget system reclassification, as well as unused contingency of $5. The remaining positive variance of $66 is due to staff vacancies, mainly due to delayed position recruitment and hard-to-recruit positions, and various delays in initiatives, including the Medical Reconciliation project, Radiation Therapy Corridor and HQCA, as well as the phased-in opening of the South Health Campus. The overall positive variance is partially offset by increased activity and the increased costs of diagnostic exams.

  There is an increase of $114 over prior year mainly attributable to inflation, increased activities and new initiatives including Kaye Edmonton Clinic, South Health Campus, HQCA, Student Health Partnership, Obesity Strategy and Medical Reconciliation. The increased activities and new initiatives led to the filling of vacant positions and new hires, further increasing costs. Increased contract costs for Dynalife and compensation rate increases rounded out the overall increase.

- **Promotion, prevention and protection services** are comprised primarily of health promotion, disease and injury prevention, health protection, and emergency preparedness.

  Promotion, prevention and protection services amounted to $337 compared to a budget of $368 resulting in a positive variance of $31 or 8.4%. Included in this variance is a positive $9 budget system reclassification. The remaining positive variance of $22 is mainly due to vacancies and delayed initiatives, including the Alberta Cancer Prevention Legacy Fund grant, Thrive on Wellness, Tobacco/Addiction contracts, pandemic supplies / disaster management and the Syphilis Prevention Campaign.

  There is an increase of $26 from prior year mainly due to increased activity levels, inflationary increases in both labour and contracts, and the filling of vacant and new positions.

- **Research and education** pertains to formally organized health research and graduate medical education, primarily funded by donations and third party contributions.

  Research and education amounted to $225 compared to a budget of $249 resulting in a positive variance of $24 or 9.6%. Included in this variance is a positive $23 budget system reclassification. The remaining positive variance of $1 is mainly related to vacancies, offset by increased medical resident costs.

  There is an increase of $7 from prior year mainly due to increased salary and benefits costs, including an increase in the number and pay rate associated with medical residents in fiscal 2013 and the filling of vacancies, along with increased activity in new initiatives. The overall increase was partially offset by decreased costs related to reduced drug usage and the completion of various research grants.

- **Administration** is comprised of human resources, finance, general administration and communications, as well as a share of administration of contracted health service providers. General administration includes senior executive and many functions such as planning and development, privacy, risk management, internal audit, infection control, quality assurance, insurance, patient safety, and legal. Activities and costs directly supporting clinical activities are excluded.

  Administration amounted to $444 compared to a budget of $436 resulting in a negative variance of $8 or 1.8%. Included in this variance is a negative $42 budget system reclassification, as well as unused contingency of $6. The remaining positive variance of $28 is mainly due to vacancies throughout the province due to hard-to-recruit positions, as well as regular revolving vacancies and timing of recruitment. Further contributing to the overall positive variance are delayed initiatives, including HQCA initiatives, Addictions & Mental Health initiatives and the opening of the South Health Campus. The overall positive variance was offset by an unbudgeted one-time PSAS transition cost for a change in discount rate on the Supplemental Executive Retirement Plan (SERP) obligation.

  There is an increase of $47 from the prior year mainly due to additional expenses related to new initiatives including South Health Campus, HQCA, and Strategic Clinical Networks, as well as increased salary and benefits costs associated with both rate increases and the recruitment of various staff and management positions, annualizations and inflation. There was also an increase related to a one-time PSAS transition cost for a change in discount rate on the SERP obligation. The overall increase was partially offset by the completion of various initiatives, including the Children's Mental Health Plan, as well as a decrease in insurance expense.

- **Information technology** is comprised of infrastructure and systems support, telecommunications, device and print services, data processing, system development and software.

  Information technology amounted to $455 compared to a budget of $480 resulting in a positive variance of $25 or 5.2%. Included in this variance is a positive $16 budget system reclassification, as well as unused contingency of $1. The remaining positive variance of $8 is mainly due to vacancies, partially offset by the timing of IT projects and related costs.

  There is an increase of $20 over prior year attributable to increased number of employees and salary and benefits rate increases, as well as increased costs related to the opening of South Health Campus and Kaye Edmonton Clinic. The overall increase in costs was partially offset by decreased costs in other expenses for the replacement of high priority clinical technology and aging end user devices, as well as a decrease in the spending on operating projects.

- **Support services** is comprised of building maintenance operations (including utilities), materials management (including purchasing, central warehousing, distribution and sterilization), housekeeping, laundry and linen services, patient registration, health records and food services.

Support services amounted to $1,843 compared to a budget of $1,841 resulting in a negative variance of $2 or 0.1%. Included in this variance is a negative $82 budget system reclassification, as well as unused contingency of $47. The remaining positive variance of $33 is mainly due to vacancies, delayed initiatives, and the phased-in opening of the South Health Campus. Included in support services is the amortization of facilities and improvements, which further increased the positive variance due mainly to the delay in various project capitalizations, the most significant of which is the South Health Campus. The overall positive variance was partially offset by increased spending on AI funded IMP projects, minor equipment purchases and increased mobility device costs.

There is an increase of $122 from the prior year mainly due to increased costs related to the opening of new facilities (South Health Campus and Kaye Edmonton Clinic), inflation, completion of an increased number of IMP projects, increased activity and new initiatives resulting in increased salaries and benefit costs and increased contracted services costs. Further contributing to the overall increase in costs are increased leasing costs and increased maintenance supplies and work done particularly with respect to the new facilities opened in the current year, as well as increased amortization due to increased capitalization of assets. The overall increase was partially offset by a decrease in minor equipment purchases and completed grant-funded projects in the prior year.

Financial Position

The following table summarizes the Consolidated Statement of Financial Position:

CONSOLIDATED STATEMENT OF FINANCIAL POSITION	2013 ACTUAL	2012 ACTUAL	INCREASE (DECREASE)	% INCREASE (DECREASE)
Cash and portfolio investments	$2,100	$2,369	$(269)	(11.4)%
Tangible capital assets	7,516	7,215	301	4.2%
All other assets	555	608	(53)	(8.7)%
Total assets	**$10,171**	**$10,192**	**$(21)**	**(0.2)%**
Deferred revenue	$6,960	$6,905	$55	0.8%
Debt	375	370	5	1.4%
All other liabilities	1,683	1,863	(180)	(9.7)%
Total liabilities	**$9,018**	**$9,138**	**$(120)**	**(1.3)%**
Total net assets	**$1,153**	**$1,054**	**$99**	**9.4%**

Cash & Portfolio Investments

The Consolidated Statement of Cash Flows summarizes the sources and uses of cash in 2012-13.

AHS receives its global funding from Alberta Health twice per month. The arrangement allows AHS to manage its operating cash balances efficiently to meet its immediate and ongoing liabilities as they become due. The AHS investment portfolio is highly liquid in nature and allows AHS to react to expected and unexpected cash requirements quickly and efficiently. Focusing on prudent stewardship of funds, AHS monitors its bank balances closely and transfers cash to or from the investment portfolio to ensure that cash balances will earn maximum returns until they need to be used. The net reduction of $269 in the overall cash and portfolio investment balance as compared to the prior year was mainly due to a reduction of accounts payable and accounts payable related to capital transactions, as well as the return of Consolidated Cash Investment Trust funds. This decrease was partially offset by a decrease in accounts receivable.

Portfolio Composition and Risk Analysis

AHS has a responsibility to ensure its funds are invested in a way that promotes the short and long-term sustainability of the organization's operations. The investment philosophy assures the preservation of capital by minimizing exposure to undue risk of loss or impairment while maintaining a reasonable expectation of fair return or appreciation while offsetting the effects of inflation.

AHS manages its investment portfolio risk through diversification in various investment vehicles such as treasury bills, federal, provincial and corporate fixed income and equity pooled funds. The short term investment strategy is designed to focus on safety and liquidity, while capturing reasonable rates of return. The longer term strategy balances federal and provincial bonds with high quality corporate fixed holdings and an equity income fund component. This strategy protects the original capital while providing reasonable returns with a conservative exposure to more volatile equity markets. The majority of cash and portfolio investments are used to fund operations in the short and medium term.

Restrictions

The total cash and portfolio investment balance of $2,100 will be used to cover future liabilities including accounts payable, deferred operating and capital costs and long term borrowing obligations, with the exception of $83 representing unrestricted net assets.

AHS manages its cash and portfolio investments prudently so that funds are available to meet current and long term commitments. As at March 31, 2013, the current balance is adequate to cover immediate and upcoming obligations as they become due.

Tangible Capital Assets

TANGIBLE CAPITAL ASSETS	2013 ACTUAL	2012 ACTUAL	INCREASE (DECREASE)
Cost	$12,569	$11,801	$768
Accumulated amortization	5,053	4,586	467
Net book value	**$7,516**	**$7,215**	**$301**

The total unamortized capital assets as at March 31, 2013 consist of $5,440 of facilities, $908 of equipment and building service equipment, $688 of work in progress (WIP), $299 of information systems, $124 of land and land improvements and $57 of leased facilities and improvements.

Over the course of the year, several capital projects totalling $2,002 in WIP were brought into service and capitalized. Notable projects included South Health Campus, Kaye Edmonton Clinic, South Health Campus Parkade, Fort Saskatchewan Health Centre and the Stollery Children's Hospital expansion.

The work in progress balance includes:

- Grande Prairie Regional Health Centre
- Strathcona Community Hospital
- Kaye Edmonton Clinic Pedway and Urology
- Alberta Hospital Edmonton
- Provincial Pay Consolidation Initiative
- South Health Campus
- Chinook Regional Hospital
- Central Alberta Cancer Centre
- Stollery Children's Hospital – various
- Alberta Children's Hospital – Neonatal Intensive Care Unit
- Edson Health Care Centre
- Medicine Hat Regional Hospital
- Lloydminster Dr Cooke Continuing Care Centre
- eCritical Alberta Project
- High Prairie Hospital
- Provincial Patient Lifts Initiative
- Provincial Communicable Diseases Initiative
- Foothills Medical Centre Expansion
- Bow Island

AHS has approved capital commitments of $59 for facilities and improvements, $44 for information systems and $44 for equipment.

The capital purchases compared to the annual amortization expense indicates the rate of reinvestment; the reinvestment rate for equipment and information systems was 141% in 2013 (2012 – 132%). As a result, the estimated remaining useful life for equipment and information systems increased from 3.5 years to 3.7 years.

Financing of Tangible Capital Assets

AHS relies significantly on external sources for funding capital expenditures. Facility purchases of $431, included in the additions to WIP, were predominantly funded by the Government, except for parkades, which are ancillary operations funded by debt. Equipment and information systems purchases of $403 were funded two-thirds externally, whereas prior year purchases of $343 were only funded one-third externally. A greater portion of equipment and information systems purchases were funded externally in 2012-13 due to their inclusion in the South Health Campus and Kaye Edmonton Clinic projects.

Expended deferred capital revenue balance represents an obligation on behalf of AHS to utilize tangible capital assets for the duration of their long-term useful lives. Funding from other government organizations, which is mainly AI, makes up $5,622 of the $6,235 total balance, while facilities makes up a similar proportion of the total tangible capital assets net book value.

Net assets invested in tangible capital assets included in accumulated surplus is $916, representing the amount of net assets already used to fund tangible capital assets internally or required to repay debt used to fund tangible capital assets. The majority of the outstanding $375 of debt was used to fund tangible capital assets.

Resources Available For Future Use

Grants, donations and fundraising are key sources of revenue for AHS. Through these funds, AHS is able to implement various operating and capital initiatives intended to improve the quality of health care in Alberta. Restricted funding is subject to timing and purpose restrictions imposed by funding agencies, which are deferred and recognized as revenue as the terms for the use of the funding are met and, when applicable, AHS complies with its communicated use.

Unexpended deferred operating revenue

During the year, AHS received or accrued $1,209 in restricted funding and spent $1,351 in related expenses. The amounts received or accrued and spent by AHS during the fiscal year pertain primarily to initiatives funded by AH grants related to physician compensation, provision of various drugs at no costs to patients, incremental operating costs of new health facilities, and safe communities. AHS has $484 available at March 31, 2013 for future use.

Unexpended deferred capital revenue

During the year, AHS received or accrued $256 in restricted capital grant funding and spent $636 on capital expenditures. AHS has $240 available at March 31, 2013 for future use.

Unrestricted net assets

During the year, AHS generated an operating surplus of $106, of which $40 was used for internally funding tangible capital asset activities. AHS has $83 of unrestricted net assets and $79 of reserves at March 31, 2013 available for future use.

Financial Reporting, Control And Accountability

Financial Reporting

Alberta Health Services was established under the Regional Health Authorities Act (Alberta), effective April 1, 2009, as a result of the amalgamation of 12 formerly separate health entities in Alberta.

The AHS consolidated financial statements have been prepared in accordance with Public Sector Accounting Standards and the reporting requirements of Alberta Health Financial Directive 9. The chart of accounts that AHS uses to report expenses by program and by object is based on the national standard of the Canadian Institute of Health Information (CIHI). Detailed site based results are submitted to CIHI annually for analysis and reporting on Canada's health system and the health of Canadians. AHS quarterly and annual financial reports are available at **www.albertahealthservices.ca** under publications.

The Auditor General is the appointed auditor of AHS. In addition to expressing an audit opinion on the AHS annual consolidated financial statements, the Auditor General also reports to the legislature significant recommendations related to AHS along with other government entities. The Auditor General's reports are available at **www.oag.ab.ca** under public reports.

Financial Control And Accountability

An effective, integrated governance model is an essential component in support of improving:

- The delivery of care and services;
- Support for people who deliver care and services; and
- The way the organization operates

The Board of Directors (the 'Board') provides oversight and carries out its risk management mandate primarily through its Board Committees which include; Audit and Finance Committee, Quality & Safety Committee, Governance Committee, Health Advisory Committee, and Human Resources Committee.

The Audit and Finance Committee has responsibility for overseeing the financial control and accountability systems of AHS. AHS has established an internal audit function with the mandate of providing independent assurance to management and the Board on AHS operations. The scope of Internal Audit's work is to determine whether AHS's risk management, control and governance processes are adequate and functioning effectively. The Chief Audit Executive is also responsible for coordinating AHS's Enterprise Risk Management policy and processes for identifying, monitoring and reporting risks within the organization.

AHS also has an Internal Controls over Financial Reporting (ICOFR) function which is tasked with ensuring that the financial reporting environment mitigates the risk of material misstatements by establishing a sustainable framework of internal controls over financial reporting. In fulfilling its mandate, ICOFR continues to work on the implementation of its plan to ensure that appropriate internal controls are designed, implemented and documented within AHS. In addition to the ICOFR program, AHS has also recently implemented a compliance program for its Human Resources department and its Contracting, Procurement and Supply Management department.

During 2012-13, AHS also underwent an external review of expense policies and processes, conducted by the Office of the Auditor General. Changes were made to the organization's expense policies and procedures, including public disclosure of approved expense reports submitted by AHS executive staff members. These changes to AHS's policy support the organization's commitment to accountability, transparency and sound financial stewardship.

Change In Accounting Framework

Effective April 1, 2012, AHS transitioned to the Public Sector Accounting Standards (PSAS) as required for government not-for-profit organizations (GNFPOs). As provided by PSAS, and based on direction from AH, AHS adopted the current public sector accounting standards used in Alberta.

The key impacts of the transition were as follows;

- AHS accrued for its liability for accumulating non-vesting sick leave on a retroactive and with restatement basis. The liability was actuarially determined as at April 1, 2011 to be $85, increasing liabilities and decreasing net assets.
- AHS, on a retroactive and with restatement basis, consolidated 28 controlled foundations, but not the 36 non-controlled foundations. The impact was as follows:

AS AT APRIL 1, 2011	
Total assets	**$220**
Total liabilities	**$113**
Total net assets	**$107**

FOR THE YEAR ENDED MARCH 31, 2012	
Total revenues	**$52**
Total expenses	**$53**

All foundations are listed in the appendix of the annual report

- As result of electing to use the exemption available for retirement and post-employment benefits, AHS recognized all SERP cumulative actuarial gains and losses totalling $3 in accumulated operating surplus as at April 1, 2011. Additionally, AHS also adopted a new discount rate methodology for its actuarial valuation in accordance with PSAS which resulted in an increase in the SERP accrued benefit obligation by $10 as at April 1, 2012 and a one-time increase in expense.
- Due to the timing of implementing changes in financial instrument standards, AHS has presented unrealized gains and losses on investments prior to April 1, 2012 as accumulated unrealized net gains and after April 1, 2012 as accumulated remeasurement gains and losses. Both are similar but slightly different. Both are reported on the Consolidated Statement of Financial Position but one provides a continuity in a note and the other in a new statement, the Consolidated Statement of Accumulated Remeasurement Gains and Losses.

Future Changes to PSAS

PSAS continues to evolve and as such, various exposure drafts have been issued for comment by the Public Sector Accounting Board which may impact future accounting and disclosure requirements. Additionally, the interpretation and application of PSAS specifically to GNFPOs continues to be debated by various stakeholders including auditors and standard setters. AHS continues to actively monitor and assess the impact of any resulting changes made to PSAS.

Forward-Looking Statements Disclosure

This FSD&A includes forward-looking statements and information about the organization's outlook, direction, operations and future financial results that are subject to risks, uncertainties and assumptions. As a consequence, actual results in the future may differ materially from any conclusion, forecast or projection in such forward-looking statements. Therefore, forward-looking statements should be considered carefully and undue reliance should not be placed on them.

Outlook

2013/14 Budget And Multi-Year Outlook

Our 2013-2016 Health Plan and Business Plan outlines a "triple aim" approach in improving health care: improving patient experience and quality of care, improving health outcomes and improving value for money. These high order dimensions informed our strategic directions:

- Bringing Appropriate Care to Your Community
- Partnering for Better Health Outcomes
- Achieving Health System Sustainability

The 2013-2016 Health Plan and Business Plan includes the 2013/14 Budget and Multi-Year Outlook and this information is available at **www.albertahealthservices.ca** under publications. Below is an overview of the 2013/14 Budget and Multi-Year Outlook:

- We expect to achieve a balanced operating position in 2013/14.
    - Total revenues will be $13,355, a 4.9% increase over 2012/13.
    - Total revenues include the base operating grant from Alberta Health of $10,521, a 3% increase over 2012/13.
    - Total expenses will be $13,355, a 4.9% increase over 2012/13.
- It is expected that we will receive a 3% increase in the base operating grant in 2014/15 and a 2% increase in 2015/16. We expect to achieve a balanced operating position in 2014/15 and 2015/16.

Long-Term Spending Trends, Cost Drivers And Sustainability

For most of the last decade, the rate of increase in health care spending in Alberta has been close to 10% per year. Although the rate of increase has slowed recently, spending has continued to grow at a significant rate.

A review of comparative information across Canada indicates that Alberta has the second highest adjusted health care expenditure per capita, along with relatively higher utilization of selected health care services and higher costs per unit of service.

Our Multi-Year Outlook and Health Plan and Business Plan for 2013-2016 are based on an in-depth understanding of the drivers of health care expenditures. Our plans include strategies to manage these cost drivers in order to achieve sustainability while moving forward on our strategic directions.

Cost drivers are grouped into four categories:

1. **Inputs and cost of inputs:**

    - Alberta's Registered Nurse (RN) and Licensed Practical Nurse (LPN) salaries are the second highest in the country.
    - Alberta has the largest volume of physicians per person, as well as a high volume of physician services per person. Alberta has the highest cost per physician claim and the highest total billings per physician.
    - Alberta has more acute care beds per adjusted capita than the national average.

2. **Inputs / unit of service:**

    - Alberta's cost per weighted case is the second highest in the country. This is likely due to higher input costs, including salary and benefit costs.

3. **Volume of services used:**

    - Consistent with the higher volume of acute care beds per capita, Alberta has more acute hospital stays than the national average (17.6 percent higher per adjusted capita than the national rate).
    - Alberta has more emergency department (ED) visits per adjusted capita than Ontario (the only other province reporting this data for all sites).

4. **Type of services used:**

    - Providing services in higher-cost settings also contributes to higher expenditures;
    - Alberta's inpatient average length of stay (ALOS) is close to the national average, but there are notable differences between typical cases where Alberta's ALOS is shorter than the national average and atypical cases are significantly longer than the national average;
    - Alberta has the longest average acute care length of stay for clients discharged to continuing care (consistent with the relatively fewer long-term care beds mentioned above).

We will limit the rate of spending increase and promote sustainability and value for money. In the short-term, we will undertake initiatives to manage unit costs, achieve operational efficiencies and productivity improvements, optimize service delivery and implement new funding models and revenue opportunities to manage costs and deliver on our strategic directions. We will also continue to work to ensure long-term sustainability. Focused efforts that guide system transformation and foster long-term sustainability will be undertaken in areas such as:

- Delivering innovative service models for complex, high needs populations;
- Strengthening community and primary health care to deliver care in the most appropriate setting; and
- Advancing the adoption of evidence-informed practices and clinical appropriateness.

Key Risks

We actively monitor and manage risks that may impact the achievement of our strategic directions. Priority risk areas for AHS are:

- Sustainable Workforce
- Organizational Sustainability
- Quality, Safety and Patient Flow
- Infrastructure
- Informed Decisions
- Health and Safety

Risk mitigation plans are being developed for each priority risk area to guide risk management activities. The plans will:

- Identify key root causes (contributing factors);
- Create short and long term mitigation strategies;
- Identify key risk indicators and/or performance measures (data driven process);
- Identify risk tolerance and risk targets for the next 3 years.

In addition to the priority risk areas, there are risks specific to the budget. We will actively manage these risks and implement mitigation strategies. These risks include:

- Compensation (e.g., the collective agreement with the United Nurses of Alberta expired on March 31, 2013 and these costs make up a significant portion of our total budget).
- Demand growth (i.e., increasing demand for health care services may result in increased expenses).
- Cost inflation (i.e., expenses may be higher than anticipated due to increased cost inflation in areas such as drugs, medical and surgical supplies and contracted services).
- Savings (i.e., the balanced operating position budgeted for 2013/14 is predicated on the achievement of savings).

The 2013-2016 Health Plan and Business Plan includes additional information on risks and mitigation strategies.

Alberta Health
Services

CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2013

Management's Responsibility for Financial Reporting

Independent Auditor's Report

Consolidated Statements of Operations

Consolidated Statements of Financial Position

Consolidated Statement of Accumulated Remeasurement Gains and Losses

Consolidated Statements of Cash Flows

Notes to the Consolidated Financial Statements

Schedule 1 – Consolidated Schedules of Expenses by Object

Schedule 2 – Consolidated Schedules of Salaries and Benefits

Schedule 3 – Consolidated Schedule of Budget

Schedule 4 – Transition to Public Sector Accounting Standards

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

The accompanying consolidated financial statements for the years ended March 31, 2013 and March 31, 2012 are the responsibility of management and have been reviewed and approved by senior management. The consolidated financial statements were prepared in accordance with Canadian Public Sector Accounting Standards and the financial directives issued by Alberta Health, and of necessity include some amounts based on estimates and judgment.

To discharge its responsibility for the integrity and objectivity of financial reporting, management maintains a system of internal accounting controls comprising written policies, standards and procedures, a formal authorization structure, and satisfactory processes for reviewing internal controls. This system provides management with reasonable assurance that transactions are in accordance with governing legislation and are properly authorized, reliable financial records are maintained, and assets are adequately safeguarded.

Alberta Health Services carries out its responsibility for the consolidated financial statements through the Audit and Finance Committee. This Committee meets with management and the Auditor General of Alberta to review financial matters, and recommends the consolidated financial statements to the Alberta Health Services Board for approval upon finalization of the audit. The Auditor General of Alberta has free access to the Audit and Finance Committee.

The Auditor General of Alberta provides an independent audit of the consolidated financial statements. His examination is conducted in accordance with Canadian Generally Accepted Auditing Standards and includes tests and procedures which allow him to report on the fairness of the consolidated financial statements prepared by management.

[Original signed by]

Dr. Chris Eagle
President and Chief Executive Officer
Alberta Health Services

[Original signed by]

Deborah Rhodes, CA
Senior Vice President Finance
Alberta Health Services

[Original signed by]

Duncan Campbell, CA
Executive Vice President and Chief Financial Officer
Alberta Health Services

June 6, 2013

AUDITOR
GENERAL
Alberta

Independent Auditor's Report

To the Members of the Alberta Health Services Board and
the Minister of Health

Report on the Consolidated Financial Statements

I have audited the accompanying consolidated financial statements of Alberta Health Services, which comprise the consolidated statements of financial position as at March 31, 2013, March 31, 2012 and April 1, 2011, and the consolidated statements of operations and cash flows for the years ended March 31, 2013 and March 31, 2012, and the consolidated statement of accumulated remeasurement gains and losses for the year ended March 31, 2013, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these consolidated financial statements based on my audits. I conducted my audits in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

I believe that the audit evidence I have obtained in my audits is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the consolidated financial statements present fairly, in all material respects, the financial position of Alberta Health Services as at March 31, 2013, March 31, 2012 and April 1, 2011, and the results of its operations and its cash flows for the years ended March 31, 2013 and March 31, 2012, and its remeasurement gains and losses for the year ended March 31, 2013 in accordance with Canadian public sector accounting standards.

[Original signed by Merwan N. Saher, FCA]

Auditor General

June 6, 2013

Edmonton, Alberta

CONSOLIDATED STATEMENTS OF OPERATIONS
YEARS ENDED MARCH 31

	2013		2012
	Budget (Note 4) (Schedule 3)	Actual	Actual (Note 2) (Schedule 4)
Revenue:			
Alberta Health transfers			
Base operating grant	$ 10,212,000	$ 10,213,791	$ 9,634,221
Other operating grants	1,164,000	1,076,481	835,412
Capital grants	96,000	106,688	120,522
Other government transfers (Note 5)	362,000	393,135	345,761
Fees and charges	439,000	412,038	416,385
Ancillary operations	127,000	117,726	121,563
Donations, fundraising and non-government grants (Note 6)	129,000	144,067	146,504
Investment and other income (Note 7)	200,000	210,677	213,691
TOTAL REVENUE	12,729,000	12,674,603	11,834,059
Expenses:			
Inpatient acute nursing services	2,923,000	2,972,309	2,760,746
Emergency and other outpatient services	1,356,000	1,406,688	1,314,344
Facility-based continuing care services	971,000	887,139	866,587
Ambulance services	415,000	409,239	394,585
Community-based care	1,054,000	1,007,326	913,748
Home care	496,000	507,009	452,823
Diagnostic and therapeutic services	2,148,000	2,074,711	1,961,249
Promotion, prevention and protection services	368,000	336,863	310,963
Research and education	249,000	224,623	218,003
Administration (Note 8)	436,000	444,358	397,278
Information technology	480,000	454,919	435,339
Support services (Note 9)	1,841,000	1,843,028	1,721,495
TOTAL EXPENSES (Schedule 1)	12,737,000	12,568,212	11,747,160
OPERATING SURPLUS (DEFICIT)	$ (8,000)	106,391	86,899
Accumulated operating surplus, beginning of year		971,723	884,824
Accumulated operating surplus, end of year (Note 19)		$ 1,078,114	$ 971,723

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENTS OF FINANCIAL POSITION

	March 31, 2013 Actual	March 31, 2012 Actual (Note 2) (Schedule 4)	April 1, 2011 Actual (Note 2) (Schedule 4)
Assets:			
Cash and cash equivalents (Note 11)	$ 684,604	$ 812,526	$ 1,124,112
Portfolio investments (Note 12)	1,415,223	1,556,246	1,406,046
Accounts receivable (Note 13)	363,421	413,500	495,392
Other assets	12,455	38,082	16,447
Tangible capital assets (Note 14)	7,515,882	7,215,171	6,707,464
Inventories for consumption	93,548	96,740	99,097
Prepaid expenses	86,119	59,586	59,980
TOTAL ASSETS	$ 10,171,252	$ 10,191,851	$ 9,908,538
Liabilities:			
Accounts payable and accrued liabilities (Note 15)	$ 1,157,924	$ 1,348,583	$ 1,284,432
Employee future benefits (Note 16)	524,827	514,515	470,966
Deferred revenue (Note 17)	6,959,575	6,905,059	6,868,912
Debt (Note 18)	375,384	369,979	336,299
TOTAL LIABILITIES	9,017,710	9,138,136	8,960,609
Net Assets:			
Accumulated operating surplus (Note 19)	1,078,114	971,723	884,824
Accumulated remeasurement gains and losses	10,221	-	-
Accumulated unrealized net gains (Note 20)	-	18,252	3,332
Endowments (Note 21)	65,207	63,740	59,773
TOTAL NET ASSETS	1,153,542	1,053,715	947,929
	$ 10,171,252	$ 10,191,851	$ 9,908,538

Contractual Obligations and Contingent Liabilities (Note 22)

The accompanying notes and schedules are part of these consolidated financial statements.

Approved by the Board of Directors

[Original signed by]

Stephen H. Lockwood, Q.C.
Chair

[Original signed by]

Don Sieben, MBA, FCA, B Com, DHSA
Audit and Finance Committee Chair

CONSOLIDATED STATEMENT OF ACCUMULATED REMEASUREMENT GAINS AND LOSSES
YEAR ENDED MARCH 31

	2013
Balance, beginning of year	$ -
Adjustment on adoption of the financial instruments standard (Note 2(c)(v))	5,272
Unrestricted unrealized net gains on portfolio investments	6,858
Unrestricted realized net gains on portfolio investments recognized in the Consolidated Statement of Operations	(1,909)
Balance, end of year (Note 12)	$ 10,221

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED MARCH 31

	2013		2012
	Budget (Note 4) (Schedule 3)	Actual	Actual (Note 2) (Schedule 4)
Operating transactions:			
Operating surplus (deficit)	$ (8,000)	$ 106,391	$ 86,899
Non-cash transactions:			
Amortization, disposals and write-downs	521,000	533,168	474,537
Recognition of expended deferred capital revenue	(374,000)	(375,307)	(342,550)
Revenue recognized for acquisition of land	-	(15)	(599)
Bond amortization expense	13,000	15,973	22,781
Decrease (increase) in:			
Accounts receivable related to operating transactions	(20,000)	56,217	87,947
Inventories for consumption	(8,000)	3,192	2,357
Other assets	18,000	25,627	(21,635)
Prepaid expenses	-	(26,533)	394
Increase (decrease) in:			
Accounts payable and accrued liabilities related to operating transactions	55,000	(94,213)	45,283
Employee future benefits	52,000	10,312	43,549
Deferred revenue related to operating transactions	(79,000)	(131,555)	(161,110)
Cash provided by operating transactions	170,000	123,257	237,853
Capital transactions:			
Acquisition of tangible capital assets	(556,000)	(527,349)	(486,916)
Increase (decrease) in accounts payable and accrued liabilities related to capital transactions	13,000	(100,600)	18,868
Cash applied to capital transactions	(543,000)	(627,949)	(468,048)
Investing transactions:			
Purchase of portfolio investments	(4,310,000)	(2,589,186)	(2,946,407)
Proceeds on sale of portfolio investments	4,522,000	2,731,366	2,788,346
Cash provided by (applied to) investing transactions	212,000	142,180	(158,061)
Financing transactions:			
Deferred capital revenue received	163,000	250,962	178,503
Deferred capital revenue returned	(107,000)	(128,042)	(15,759)
Deferred capital revenue payable transferred from (to) accounts payable and accrued liabilities	107,000	119,754	(119,754)
Proceeds from debt	32,000	32,300	194,000
Principal payments on debt	(38,000)	(40,384)	(160,320)
Cash provided by financing transactions	157,000	234,590	76,670
Net decrease in cash and cash equivalents	(4,000)	(127,922)	(311,586)
Cash and cash equivalents, beginning of year	837,000	812,526	1,124,112
Cash and cash equivalents, end of year	$ 833,000	$ 684,604	$ 812,526

The accompanying notes and schedules are part of these consolidated financial statements.

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2013

Note 1 Authority, Purpose and Operations

Alberta Health Services (AHS) was established under the *Regional Health Authorities Act* (Alberta), effective April 1, 2009, as a result of the amalgamation of 12 formerly separate health entities in Alberta.

Pursuant to the *Regional Health Authorities Act* (Alberta), AHS is responsible in Alberta to:

- promote and protect the health of the population and work toward the prevention of disease and injury;
- assess on an ongoing basis the health needs of the population;
- determine priorities in the provision of health services and allocate resources accordingly;
- ensure reasonable access to quality health services; and
- promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities.

Additionally, AHS is accountable to the Minister of Health (the Minister) for the delivery and operation of the public health system.

The AHS consolidated financial statements include the revenue and expenses associated with its responsibilities. These consolidated financial statements do not reflect the complete costs of provincial health care. For example, the Ministry of Health is responsible for paying most physician fees. For a complete picture of the costs of provincial healthcare, readers should consult the Consolidated Financial Statements of the Government of Alberta.

AHS and its contracted health service providers deliver health services at facilities and sites grouped in the following areas: addiction treatment, community mental health, standalone psychiatric facilities, acute care hospitals, sub-acute care in auxiliary hospitals, long-term care, palliative care, supportive living, cancer care, community ambulatory care centres and urgent care centres.

AHS and its consolidated entities listed in Note 3(a) are exempt from the payment of income taxes under the *Income Tax Act* (Canada).

Note 2 Transition to Public Sector Accounting Standards

Commencing with the 2012-13 fiscal year, AHS became a first-time adopter of the CICA Public Sector Accounting Standards (PSAS). Prior to 2012-13, AHS followed the recommendations of the Canadian Institute of Chartered Accountants (CICA) Accounting Handbook Part V (CGAAP).

(a) Impact of Transition

The impact of the conversion on the Consolidated Statements of Operations, Consolidated Statements of Financial Position, Consolidated Statements of Cash Flows and Consolidated Schedules of Expenses by Object are presented in Schedule 4. The key impacts on the adoption of these new standards are as follows:

	Accumulating Non-Vesting Sick Leave Liability[(i)]	Controlled Foundations[(ii)]	Other	Total
As at April 1, 2011:				
Total assets	$ -	$ 219,693	$ (6,648)	$ 213,045
Total liabilities	85,441	113,267	-	198,708
Total net assets	(85,441)	106,426	(6,648)	14,337
For the year ended March 31, 2012:				
Total revenue	$ -	$ 51,699	$ 599	$ 52,298
Total expenses	928	53,089	(4,027)	49,990
Operating surplus (deficit)	$ (928)	$ (1,390)	$ 4,626	$ 2,308
Cash provided by (applied to):				
Operating transactions	$ -	$ (3,289)	$ 284,641	$ 281,352
Capital transactions	-	-	-	-
Investing transactions	-	10,030	(404,947)	(394,917)
Financing transactions	-	7,422	-	7,422

(i) Accumulating Non-Vesting Sick Leave Liability

Under PSAS, AHS is required, on a retroactive and with restatement basis, to accrue for its liability for accumulating non-vesting sick leave. This liability was actuarially determined as at April 1, 2011 (Note 16(a)).

(ii) Controlled Foundations

Under PSAS, AHS is required, on a retroactive and with restatement basis, to consolidate its controlled foundations.

(b) Exemptions

PS 2125 permits a first-time adopter to elect certain exemptions in presenting its opening Consolidated Statements of Financial Position. AHS has elected to use the following exemptions:

(i) Retirement and Post-Employment Benefits

Based on PS 3250 – Retirement Benefits and PS 3255 – Post-employment Benefits, Compensated Absences and Termination Benefits, a government organization amortizes actuarial gains and losses to the liability or asset, and the related expense in a systematic and rational manner over the expected average remaining service life of the related employee group or a reasonable future period for plans with no active members. Retroactive application of this approach requires a government organization to split the cumulative actuarial gains and losses from the inception of the plan until the date of transition to PSAS into a recognized portion and an unrecognized portion. However, a first-time adopter may elect to recognize all cumulative actuarial gains and losses at the date of transition to PSAS directly in accumulated operating surplus (deficit).

Note 2 **Transition to Public Sector Accounting Standards (continued)**

Additionally, according to PS 3250 and PS 3255, accrued benefit obligations, post-employment benefits and compensated absences are determined by a government organization by applying a discount rate with reference to its plan asset earnings or with reference to its cost of borrowing. Retroactive application of PS 3250 and PS 3255 requires a government organization to recalculate accrued benefit obligations, post-employment benefits and compensated absences at the time of transition to PSAS. However, a first-time adopter may elect to delay application of PS 3250 and PS 3255 relative to the discount rate used until the date of their next actuarial valuation or within three years of the transition date to PSAS, whichever is sooner.

AHS has elected to use these exemptions and therefore recognized all cumulative unamortized actuarial losses as at April 1, 2011 totaling $6,559 in accumulated operating surplus. Actuarial gains and losses arising after April 1, 2011 are accounted for in accordance with PS 3250 and PS 3255 where AHS will amortize actuarial gains and losses to the liability or asset over the average remaining service life of the related employee group. In addition AHS has elected to apply PS 3250 and PS 3255 relative to the use of the discount rate for the actuarial valuation as at April 1, 2012; the accrued benefit obligation increased by $9,632.

(ii) Business Combinations

PS 2510 – Additional Areas of Consolidation, requires the purchase method to be applied to all business combinations. While the purchase method has been used previously, the details of the purchase method may vary with the accounting framework change. Retroactive application would therefore require a government organization to revisit all prior business combinations to review the identified assets and liabilities, and then assess if the values assigned are in accordance with PS 2510.

AHS has elected to use this exemption and has applied PS 2510 from the date of transition and has therefore excluded from its opening Consolidated Statement of Financial Position any item recognized under previous financial reporting standards that does not qualify for recognition as an asset or liability.

(iii) Tangible Capital Asset Impairment

PS 3150 – Tangible Capital Assets, indicates the conditions for accounting for a write-down of a tangible capital asset. A first-time adopter need not comply with those requirements for write-downs of tangible capital assets that were incurred prior to the date of transition to PSAS. If a first-time adopter uses this exemption, the conditions for a write-down of a tangible capital asset in PS 3150 are applied on a prospective basis from the date of transition.

AHS has elected to use this exemption and therefore adopted PS 3150 on a prospective basis from the date of transition and has not revisited any prior write-downs relative to the new PSAS requirements.

In accordance with the requirements of PS 2125, the accounting policies set out in Note 3 have been consistently applied to all years presented and adjustments resulting from the adoption of the new accounting standards have been applied retroactively with restatement of prior periods excluding cases where the optional exemptions available under PS 2125 have been applied and excluding sections which were released after August 2010 and to which PS 2125 does not apply. AHS's adoption of PSAS standards released after August 2010 is described in Note 2(c).

Note 2 Transition to Public Sector Accounting Standards (continued)

(c) Other Considerations

AHS has also adopted the following sections that are effective April 1, 2012. Other than previously stated in this note, there were no transition adjustments required for adopting these sections.

(i) Financial Statement Presentation

PS 1201 – Financial Statement Presentation establishes general reporting principles and standards for the disclosure of information in the consolidated financial statements. This section applies in the period when PS 2601 – Foreign Currency Translation and PS 3450 – Financial Instruments are adopted. AHS has adopted PS 1201 as at April 1, 2012.

(ii) Foreign Currency Translation

PS 2601 – Foreign Currency Translation establishes standards on how to account for and report transactions that are denominated in a foreign currency. Even though this section applies to fiscal periods beginning on or after April 1, 2012, and permits early adoption, the application of this section retroactively is prohibited when an organization applies it in the same period it adopts PSAS for the first time. This section is applied in the period when PS 3450 – Financial Instruments is adopted. AHS has adopted PS 2601 as at April 1, 2012.

(iii) Portfolio Investments

PS 3041 – Portfolio Investments establishes standards on how to account for and report portfolio investments in the consolidated financial statements. This section applies in the period when PS 1201 – Financial Statement Presentation, PS 2601 – Foreign Currency Translation, and PS 3450 – Financial instruments are adopted. AHS has adopted PS 3041 as at April 1, 2012.

(iv) Government Transfers

PS 3410 – Government Transfers deals with how to account for and report government transfers. AHS has adopted this section retroactively with restatement as at April 1, 2012.

(v) Financial Instruments

PS 3450 – Financial Instruments deals with how to account for and report all types of financial instruments including derivatives. Even though the section applies to fiscal periods beginning on or after April 1, 2012, and permits early adoption, the application of this section retroactively is prohibited when an organization applies it in the same period it adopts PSAS for the first time. This section is applied in the period when PS 2601 – Foreign Currency Translation is adopted. AHS has adopted PS 3450 as at April 1, 2012.

Note 3 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

AHS operates as a Government Not-for-Profit Organization (GNPO). These consolidated financial statements have been prepared in accordance with PSAS and the financial directives issued by Alberta Health (AH).

These financial statements have been prepared on a consolidated basis. The transactions between AHS and the following entities have been eliminated on consolidation.

Note 3 Significant Accounting Policies and Reporting Practices (continued)

(i) Wholly Owned Subsidiaries

- Calgary Laboratory Services Ltd. (CLS), who provides medical diagnostic services in Calgary and southern Alberta.
- Capital Care Group Inc. (CCGI), who manages continuing care programs and facilities in the Edmonton area.
- Carewest, who manages continuing care programs and facilities in the Calgary area.

(ii) Controlled Foundations

The following are the foundations controlled by AHS as at March 31, 2013:

Alberta Cancer Foundation (ACF)
Bassano and District Health Foundation
Bow Island and District Health Foundation
Brooks and District Health Foundation
Calgary Health Trust (CHT)
Canmore and Area Health Care Foundation
Cardston and District Health Foundation
Claresholm and District Health Foundation
Crowsnest Pass Health Foundation
David Thompson Health Trust
Fort Macleod and District Health Foundation
Fort Saskatchewan Community Hospital Foundation
Grande Cache Hospital Foundation
Grimshaw/Berwyn Hospital Foundation
Jasper Health Care Foundation
Lacombe Hospital and Care Centre Foundation
Medicine Hat and District Health Foundation
Mental Health Foundation
North County Health Foundation
Oyen and District Health Care Foundation
Peace River and District Health Foundation
Ponoka and District Health Foundation
Stettler Health Services Foundation
Strathcona Community Hospital Foundation
Tofield and Area Health Services Foundation
Viking Health Foundation
Vulcan County Health and Wellness Foundation
Windy Slopes Health Foundation

The following foundations are also considered controlled, but are in the process of being wound-up or are considered to be inactive:

Central Peace Hospital Foundation
Lakeland Regional Health Authority
Manning Community Health Centre Foundation
McLennan Community Health Care Foundation
Peace Health Region Foundation
Vermillion and Region Health and Wellness Foundation

(iii) Government Partnerships

AHS uses the proportionate consolidation method to account for its 30% interest in the HUTV Limited Partnership (HUTV) with David Chittick Management Ltd, its 50% interest in the Northern Alberta Clinical Trials Centre (NACTRC) partnership with the University of Alberta, and its 50% interest in the Primary Care Network (PCN) government partnerships with physician groups (Note 24).

AHS has joint control with various physician groups over PCNs. AHS entered into local primary care initiative agreements to jointly manage and operate the delivery of primary care services, to achieve the PCN business plan objectives, and to contract and hold property interests required in the delivery of PCN services.

Note 3 **Significant Accounting Policies and Reporting Practices (continued)**

The following PCNs are included in these consolidated financial statements:

Alberta Heartland Primary Care Network
Athabasca Primary Care Network
Big Country Primary Care Network
Bonnyville / Aspen Primary Care Network
Bow Valley Primary Care Network
Calgary Foothills Primary Care Network
Calgary Rural Primary Care Network
Calgary West Central Primary Care Network
Camrose Primary Care Network
Chinook Primary Care Network
Cold Lake Primary Care Network
Edmonton North Primary Care Network
Edmonton Oliver Primary Care Network
Edmonton Southside Primary Care Network
Edmonton West Primary Care Network
Grande Prairie Primary Care Network
Highland Primary Care Network
Kalyna Country Primary Care Network
Leduc Beaumont Devon Primary Care Network
Lloydminster Primary Care Network
McLeod River Primary Care Network
Mosaic Primary Care Network
Northwest Primary Care Network
Palliser Primary Care Network
Peace Region Primary Care Network
Provost/Consort Primary Care Network
Red Deer Primary Care Network
Rocky Mountain House Primary Care Network
Sexsmith/Spirit River Primary Care Network
Sherwood Park-Strathcona County Primary Care Network
South Calgary Primary Care Network
St. Albert & Sturgeon Primary Care Network
St. Paul / Aspen Primary Care Network
Vermilion Primary Care Network
Wainwright Primary Care Network
West Peace Primary Care Network
WestView Primary Care Network
Wetaskiwin Primary Care Network
Wolf Creek Primary Care Network
Wood Buffalo Primary Care Network

(iv) Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP)

AHS consolidates its interest in the LPIP. AHS has the majority of representation on the LPIP's governance board and is therefore considered to control the LPIP. The main purpose of the LPIP is to share the risks of general and professional liability to lessen the impact on any one subscriber. The LPIP is exempt from the payment of income tax but is subject to the Alberta provincial premium tax.

(v) Other

These consolidated financial statements include the assets, liabilities and operations of the Queen Elizabeth II Hospital Child Care Centre and the trust funds administered by the Capital Care Charitable Trust.

These consolidated financial statements include the payments to voluntary and private organizations under contract to provide health services in the Province of Alberta (Note 10). Also included are certain tangible capital assets owned by AHS but operated by contacted health service providers. Other operations not funded by AHS and other assets and liabilities of the contracted health service providers are not included in these consolidated financial statements. These consolidated financial statements do not include the Health Benefit Trust of Alberta (HBTA) or trust funds administered on behalf of others (Note 25).

Note 3 **Significant Accounting Policies and Reporting Practices (continued)**

(b) Revenue Recognition

Revenue is recognized in the period in which the transactions or events occur that give rise to the revenue as described below. All revenue is recorded on an accrual basis, except when the accrual cannot be determined within a reasonable degree of certainty or when estimation is impracticable.

(i) Government Grants

Transfers from AH, other governments and other government entities are referred to as government grants.

Government grants are recorded as deferred revenue if the terms for use of the grant, or the terms along with AHS's actions and communications as to the use of the grant, create a liability. These grants are recognized as revenue as the terms are met and, when applicable, AHS complies with its communicated use of the grant.

All other government grants without terms for the use of the grant are recorded and recognized as revenue when AHS is eligible to receive the funds.

(ii) Donations, Fundraising and Non-government Grants

Donations, fundraising, and non-government grants are received from individuals, corporations, and other not-for-profit organizations. Donations, fundraising, and non-government grants may be unrestricted or externally restricted for operating or capital purposes.

Unrestricted donations, fundraising, and non-government grants are recorded and recognized as revenue in the year received or in the year the funds are committed to AHS if the amount can be reasonably estimated and collection is reasonably assured.

Externally restricted donations, fundraising, non-government grants, realized gains and losses, and unrealized gains and losses as at April 1, 2012 (Note 3(d)(i)) for the associated externally restricted investment income are recorded as a liability until the resources are used for their specified purpose or the purpose which AHS has publicly communicated at which time the donations or grants are recognized as revenue.

In-kind donations of services and materials are recorded at fair value when such value can reasonably be determined. While volunteers contribute a significant amount of time each year to assist AHS, the value of their services is not recognized as revenue and expenses in the consolidated financial statements because fair value cannot be reasonably determined.

(iii) Grants and Donations of or for Land

AHS records grants and donations to buy land as a liability when received, and recognizes as revenue when AHS buys the land. AHS recognizes in-kind contributions of land as revenue at the fair value of the land when a fair value can be reasonably determined. When AHS cannot determine the fair value, it records such in-kind contributions at nominal value.

(iv) Endowments

Donations, fundraising, government grants and non-government grants that must be maintained in perpetuity are recognized as a direct increase in endowment net assets when received or receivable.

All unrealized gains and losses attributable to endowments are recognized as an increase or decrease in deferred revenue.

Note 3 **Significant Accounting Policies and Reporting Practices (continued)**

Expendable realized gains and losses attributable to endowments are recognized as increases or decreases in deferred revenue when received or receivable and are subsequently recognized in the Consolidated Statement of Operations when terms of use are met, as stipulated by the donors. Realized investment gains for endowment capital preservation purposes, are recognized as a direct increase in endowment net assets when received or receivable.

(v) Earned Revenue

Earned revenue includes fees and charges, ancillary operations, and other income. Earned revenue is recognized in the period that goods are delivered or services are provided.

(vi) Investment Income

Investment income includes dividend and interest income, and realized gains or losses on the sale of portfolio investments. Unrealized gains and losses on portfolio investments that are not from restricted grants or donations are recognized in the Consolidated Statement of Accumulated Remeasurement Gains and Losses until the related investments are sold. Once realized, these gains or losses are recognized in the Consolidated Statement of Operations except for restricted investment income which is recognized as revenue in the period the related expenses are incurred, or the terms of use are met.

(c) Expenses

The key elements of AHS's expense recognition policy are:

(i) Directly incurred expenses are reported on an accrual basis. The cost of all goods consumed and services received during the year are expensed.

Expenses include grants and transfers under shared cost agreements. Grants and transfers are recorded as expenses when the transfer is authorized and eligibility criteria have been met by the recipient.

(ii) Expenses incurred include contracted health services provided by other entities in support of AHS's responsibilities and operations and are disclosed in Note 10.

Note 3 Significant Accounting Policies and Reporting Practices (continued)

(d) Financial Instruments

The following describes the financial instruments accounting policies from April 1, 2012 and prior to April 1, 2012.

(i) Financial instruments from April 1, 2012

Effective April 1, 2012 AHS has adopted PS 3450 – Financial Instruments on a prospective basis (Note 2(c)(v)).

The following table identifies AHS's financial assets and liabilities and identifies how they are subsequently measured:

Financial Assets and Liabilities	Classification	Subsequent Measurement and Recognition
Cash and cash equivalents and portfolio investments	Fair value	Measured at fair value with changes in fair values recognized in the Consolidated Statement of Accumulated Remeasurement Gains and Losses, accounts payable or deferred revenue until realized at which time the cumulative changes in fair value are recognized in the Consolidated Statements of Operations.
Accounts receivable, accounts payable and accrued liabilities and debt	Cost or amortized cost	Measured at amortized cost using the effective interest rate method.

PS 3450 requires portfolio investments in equity instruments to be recorded under the fair value category and AHS may choose to record other financial assets under the fair value category if there is an investment strategy to evaluate the performance of a group of these financial assets on a fair value basis. AHS has designated money market securities and fixed income securities to the fair value category. The three levels of information that may be used to measure fair value are:

- Level 1 - Unadjusted quoted market prices in active markets for identical assets or liabilities;
- Level 2 - Observable or corroborated inputs, other than level 1, such as quoted prices for similar assets or liabilities in inactive markets or market data for substantially the full term of the assets or liabilities; and
- Level 3 - Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets and liabilities.

AHS measures and recognizes embedded derivatives separately from the host contract when the economic characteristics and risk of the embedded derivative are not closely related to those of the host contract, when it meets the definition of a derivative and when the entire contract is not measured at fair value. Embedded derivatives are recorded at fair value. For the year ended March 31, 2013, AHS has no embedded derivatives that require separation from the host contract.

All financial assets are assessed for impairment on an annual basis. When a decline is determined to be other than temporary, the amount of the loss is reported as a realized loss.

Note 3 Significant Accounting Policies and Reporting Practices (continued)

(ii) Financial instruments prior to April 1, 2012

AHS had classified its financial assets and financial liabilities in the preceding years (Schedule 4) as follows:

Financial Assets and Liabilities	Classification	Subsequent Measurement and Recognition
Cash and cash equivalents	Held for trading	Measured at fair value with changes in fair value recognized in the Consolidated Statements of Operations.
Investments	Available for sale	Measured at fair value with changes in fair value recognized in the Accumulated Net Unrealized Gain (Losses) on Portfolio Investments until realized, at which time the cumulative changes in fair value are recognized in the Consolidated Statements of Operations.
	Held for trading	Measured at fair value with changes in fair value recognized in the Consolidated Statements of Operations.
Accounts receivable, contributions and capital contributions receivable from AH	Loans and receivables	After initial fair value measurement, measured at amortized cost using the effective interest rate method.
Accounts payable and accrued liabilities and debt	Other financial liabilities	After initial fair value measurement, measured at amortized cost using the effective interest rate method.

In the prior year, AHS did not use hedge accounting and was not impacted by the requirements of CICA accounting standard Section 3865 – Hedges. AHS, as a not-for-profit organization, elected to not apply the standards for embedded derivatives in non-financial contracts. In addition, AHS elected not to adopt Section 3862 Financial Instruments – Disclosures and Section 3863 Financial Instruments – Presentation, and instead continued to disclose financial instruments under 3861 – Financial Instruments Disclosure and Presentation.

When it was determined that an impairment of a financial instrument classified as available for sale is other than temporary, the cumulative loss that had been recognized directly in net assets or deferred contributions was removed and recognized in the Consolidated Statements of Operations even though the financial asset had not been derecognized. Impairment losses recognized in the Consolidated Statements of Operations for a financial instrument classified as available for sale are not reversed.

(iii) Transaction costs associated with the acquisition and disposal of cash and cash equivalents and portfolio investments are expensed as incurred. Investment management fees are expensed as incurred. The purchase and sale of cash and cash equivalents and portfolio investments are accounted for using trade-date accounting.

(e) Inventories For Consumption

Inventories for consumption or distribution at no charge are valued at lower of cost (defined as moving average cost) and current replacement value.

Note 3 Significant Accounting Policies and Reporting Practices (continued)

(f) Tangible Capital Assets

Tangible capital assets and work in progress are recorded at cost, which includes amounts that are directly attributable to the acquisition, construction, development or betterment of the assets. Cost includes overhead directly attributable to construction and development including interest costs that are directly attributable to the acquisition or construction of the asset. Tangible capital assets and work in progress acquired from other government organizations are recorded at the carrying value of that government organization. Costs incurred by Alberta Infrastructure (AI) to build tangible capital assets on behalf of AHS are recorded by AHS as work in progress and expended deferred capital revenue as AI incurs costs.

The threshold for capitalizing new systems development is $250 and major enhancements is $100.The threshold for all other tangible capital assets is $5. All land is capitalized.

Tangible capital assets are amortized over their estimated useful lives on a straight-line basis as follows:

	Useful Life
Facilities and improvements	10-40 years
Equipment	2-20 years
Information systems	3-5 years
Leased vehicles, facilities and improvements	Term of lease
Building service equipment	5-40 years
Land improvements	5-40 years

Work in progress, which includes facilities and improvements projects and development of information systems, is not amortized until after a project is complete.

Leases transferring substantially all benefits and risks of capital asset ownership are reported as tangible capital asset acquisitions financed by long-term obligations. These capital lease obligations are recorded at the present value of the minimum lease payments excluding executor costs (e.g. insurance, maintenance costs, etc.). The discount rate used to determine the present value of the lease payments is the lower of AHS's rate for incremental borrowing or the interest rate implicit in the lease (if known). Note 18(d) provides a schedule of repayments and amount of interest on the leases.

Tangible capital assets are written down when conditions indicate that they no longer contribute to AHS's ability to provide goods and services, or when the value of future economic benefits associated with the tangible capital assets are less than their net book value. The net write-downs are accounted for as expenses in the Consolidated Statements of Operations. Write-downs are not reversed.

Contributed tangible capital assets are recorded at their fair value on the date of donation. When AHS cannot determine the fair value, in-kind contributions are recorded at a nominal value.

Intangible assets, works of art, historical treasures and collections are not recognized in these consolidated financial statements.

Note 3 **Significant Accounting Policies and Reporting Practices (continued)**

(g) Employee Future Benefits

(i) Registered Benefit Pension Plans

AHS participates in the following registered defined benefit pension plans: the Local Authorities Pension Plan (LAPP) and the Management Employees Pension Plan (MEPP). These multi-employer public sector defined benefit plans provide pensions for participants, based on years of service and final average earnings. Benefits for post-1991 service payable under these plans are limited by the *Income Tax Act* (Canada). The Minister of Treasury Board and Finance is the legal trustee and administrator of the plans. The Department of Treasury Board and Finance accounts for the liabilities for pension obligations as a participating employer for former and current employees in the LAPP and the MEPP for all of the organizations included in the Government of Alberta (GOA) consolidated reporting entity except for government business enterprises. As AHS is included in the GOA consolidated reporting entity AHS follows the standards for defined contribution accounting for these pension plans under PS 3250. Accordingly, the pension expense recorded for these plans in these consolidated financial statements is comprised of the employer contributions that AHS is required to pay for its employees during the fiscal year.

(ii) Other Defined Contribution Pension Plans

AHS sponsors Group Registered Retirement Savings Plans (GRRSPs) for certain employee groups. Under the GRRSPs, AHS matches a certain percentage of any contribution made by plan participants up to certain limits. AHS also sponsors a defined contribution pension plan for certain employee groups where the employee and employer each contribute specified percentages of pensionable earnings.

(iii) Supplemental Executive Retirement Plans (SERPs)

AHS sponsors SERPs which are funded and has three Retirement Compensation Arrangements (RCA) for these plans. These plans cover certain employees and supplement the benefits under AHS's registered plans that are limited by the *Income Tax Act* (Canada). Each plan was closed to new entrants effective April 1, 2009. A majority of the SERPs are final average plans; however, certain participant groups have their benefits determined on a career average basis. Also, some participant groups receive post-retirement indexing similar to the benefits provided under the registered defined benefit pension plans; while others receive non-indexed benefits.

Due to *Income Tax Act* (Canada) requirements, the SERPs are subject to the RCA rules; therefore approximately half the assets are held in a non-interest bearing Refundable Tax Account with the Canada Revenue Agency. The remaining assets of the SERPs are invested in a fixed income portfolio.

The obligations and costs of these benefits are determined annually through an actuarial valuation as at March 31 using the projected benefit method pro-rated on service. Under PSAS, first-time adopters are required to recalculate accrued benefit obligations on a retroactive with restatement basis by applying a discount rate based on plan asset earnings or with reference to its cost of borrowing. However, AHS has elected to use the PSAS first-time adoption exemption that allows AHS to delay application relative to the discount rate. AHS has elected to use a discount rate based on plan asset earnings to recalculate the accrued benefit obligation as at April 1, 2012.

Note 3 Significant Accounting Policies and Reporting Practices (continued)

The net retirement benefit cost of SERPs reported in these consolidated financial statements is comprised of the retirement benefits expense and the retirement benefits interest expense. The key components of retirement benefits expense include the current period benefit cost, cost of any plan amendments including related net actuarial gains or losses incurred in the period, gains and losses from any plan settlements or curtailments incurred in the period, and amortization of actuarial gains and losses. The retirement benefits interest expense is net of the interest cost on the accrued benefit obligation and the expected return on plan assets. As a result of the transition to PSAS, the cumulative unamortized actuarial gains and losses, unamortized past service costs and unamortized initial obligations as at April 1, 2011 have been recognized and the appropriate adjustment made to accumulated operating surplus. Thereafter, actuarial gains and losses that arise will be accounted for in accordance with PSAS whereby AHS will amortize actuarial gains and losses from the liability or asset over the average remaining service life of the related employee group.

Prior period service costs arising from plan amendments are recognized in the period of the plan amendment. When an employee's accrued benefit obligation is fully discharged, all unrecognized amounts associated with that employee are fully recognized in the net retirement benefit cost in the following year.

In the case of a curtailment event which results in the elimination for a significant number of active employees of the right to earn defined benefits for their future services, a curtailment gain or loss is recorded. Gains and losses determined upon a curtailment are accounted for in the period of the curtailment.

(iv) Supplemental Pension Plan (SPP)

Subsequent to April 1, 2009, staff who would have been eligible for SERP, are enrolled in a defined contribution SPP. Similar to the SERP, the SPP supplements the benefits under AHS registered plans that are limited by the *Income Tax Act* (Canada). AHS contributes a certain percentage of an eligible employee's pensionable earnings, excluding pay at risk, in excess of the limits of the *Income Tax Act* (Canada). This plan provides participants with an account balance at retirement based on the contributions made to the plan and investment income earned on the contributions based on investment decisions made by the participant.

(v) Sick Leave Liability

Sick leave benefits accumulate with employee service and are provided by AHS to certain employee groups of AHS, as defined by employment agreements, to cover illness related absences that are outside of short-term and long-term disability coverage. Benefit amounts are determined and accumulate with reference to employees' final earnings at the time they are paid out. The cost of the accumulating non-vesting sick leave benefits is expensed as the benefits are earned.

AHS accrues its liabilities for accumulating non-vesting sick leave benefits but does not record a liability for replenishing sick leave benefits as these are renewed annually and do not represent a long-term liability. The sick leave liability is included in employee future benefits (Note 16) in the Consolidated Statements of Financial Position.

(vi) Other Benefits

AHS provides its employees with basic life, accidental death and dismemberment, short-term disability, long-term disability, extended health, dental and vision benefits through benefits carriers. AHS fully accrues its obligations for employee non-pension future benefits.

Note 3 Significant Accounting Policies and Reporting Practices (continued)

(h) Net Assets

Net assets represent the difference between the carrying value of assets held by AHS and its liabilities.

PSAS requires a "net debt" presentation for the statement of financial position in the summary financial statements of government. Net debt presentation reports the difference between financial assets and liabilities as "net debt" or "net financial assets" as an indicator of the future revenue required to pay for past transactions and events. AHS operates within the government reporting entity, and does not finance all of its expenditures by independently raising revenue. Accordingly, these consolidated financial statements do not report a net debt indicator.

(i) Measurement Uncertainty

The consolidated financial statements, by their nature, contain estimates and are subject to measurement uncertainty. Measurement uncertainty exists when there is a significant variance between the recognized or disclosed amount and another reasonably possible amount. The amounts recorded for amortization of tangible capital assets and recognition of expended deferred capital revenue are based on the estimated useful life of the related assets. The amounts recorded for employee future benefits are based on estimated future cash flows. The provision for unpaid claims, allowance for doubtful accounts and accrued liabilities are subject to significant management estimates and assumptions. These estimates and assumptions are reviewed at least annually. Actual results could differ from the estimates determined by management in these consolidated financial statements, and these differences, which may be material, could require adjustment in subsequent reporting periods.

(j) Future Accounting Changes

In June 2010 the Public Sector Accounting Board issued PS 3260 – Liability for Contaminated Sites. This accounting standard is effective for fiscal years starting on or after April 1, 2014. Contaminated sites are a result of contamination being introduced into air, soil, water or sediment of a chemical, organic, or radioactive material, or live organism that exceeds an environment standard. AHS would be required to recognize a liability related to the remediation of such contaminated site subject to certain recognition criteria. Management is currently assessing the impact of this adoption on the consolidated financial statements and cannot provide an estimate of any liability at this time.

Note 4 Budget

The AHS Health Plan and Business Plan 2012-15, which included the 2012-13 annual budget, was approved by the members of AHS Board (AHS Board) on May 3, 2012. The budget details were presented under CGAAP but included a reconciliation for PSAS transition adjustments. Schedule 3 demonstrates how the AHS Board approved budget under CGAAP for 2012-13 has been transitioned fully to PSAS. The AHS Board approved a budgeted operating deficit of $8,000 for 2012-13 under PSAS.

Note 5 Other Government Transfers

Other government transfers include amounts transferred from provincial and federal governments, excluding AH as separately disclosed.

	2013	2012
Unrestricted operating transactions	$ 48,807	$ 57,320
Restricted operating transactions	105,203	86,895
Restricted capital transactions	239,125	201,546
	$ 393,135	$ 345,761

Note 6 Donations, Fundraising and Non-government Grants

	2013	2012
Unrestricted operating transactions	$ 2,181	$ 3,530
Restricted operating transactions	112,392	122,703
Restricted capital transactions	29,494	20,271
	$ 144,067	$ 146,504

Note 7 Investment and Other Income

	2013	2012
Investment income	$ 42,724	$ 38,106
Other income:		
External recoveries	99,509	116,963
External recoveries for administration provided to others (Note 8)	5,247	4,803
Purchase incentives and rebates	28,917	17,745
Other revenue	34,280	36,074
	$ 210,677	$ 213,691

Note 8 Administration

	2013	2012
General administration[a]	$ 197,550	$ 157,837
Human resources[b]	103,105	96,033
Finance[c]	64,551	63,096
Communications[d]	20,202	23,270
Administration expense of contracted health service providers (Note 10)[e]	58,950	57,042
Total administration expense	$ 444,358	$ 397,278
Less external recoveries for administration provided to others (Note 7)	(5,247)	(4,803)
Net administration expense	$ 439,111	$ 392,475

Net administration expense has been presented to align with the Canadian Institute of Health Information definition, which includes a reclassification of communications previously disclosed as support services. Activities and costs directly supporting clinical activities are not included in administration.

(a) General administration includes senior leaders' expenses, the Board of Trustees, and other administrative functions such as planning and development, privacy, risk management, internal audit, infection control, quality assurance, insurance, patient safety, and legal.

(b) Human resources includes personnel services, staff recruitment and selection orientation, labour relations, employee health and employee record keeping.

(c) Finance includes the recording, monitoring and reporting of the financial and statistical aspects of AHS's planned and actual activities.

(d) Communications includes the receipt and transmittal of AHS's communications including telephone, paging, monitors, telex, fax, visitor information and mail services. It also includes personnel dedicated to maintenance and repair of communication systems and devices.

(e) Administrative expense of contracts with health service providers is an allocation for general administration, human resources, finance and communication expenses incurred by voluntary and private health service providers with whom AHS contracts for health services. The allocation of expenses for contracts with health service providers is in Note 10.

Note 9 Support Services

	2013	2012
Facilities operations	$ 731,741	$ 673,871
Patient health records, food services and transportation	328,965	308,578
Material management	197,888	190,091
Housekeeping, laundry and linen	196,844	188,815
Support services expense of contracted health service providers (Note 10)	113,808	105,027
Ancillary operations	110,337	99,179
Fundraising expenses and grants awarded	35,314	32,902
Other	128,131	123,032
	$ 1,843,028	$ 1,721,495

Note 10 Contracts with Health Service Providers

AHS is responsible for the delivery and operation of the public health system in Alberta (Note 1). To this end, AHS contracts with various voluntary and private health service providers to continue to provide health services throughout Alberta. The largest of these service providers is Covenant Health; the total amount funded to Covenant Health during the year was $666,381 (2012 - $640,982).

Direct AHS funding provided and allocation of expenses in the Consolidated Statements of Operations is as follows:

	2013	2012
Voluntary health service providers	$ 1,061,526	$ 1,005,079
Private health service providers	1,104,743	1,013,181
Total direct AHS funding	$ 2,166,269	$ 2,018,260

	2013	2012
Inpatient acute nursing services	$ 286,308	$ 269,975
Emergency and other outpatient services	87,787	84,166
Facility-based continuing care services	543,821	537,863
Ambulance services	153,199	150,226
Community-based care	407,065	346,403
Home care	175,647	145,997
Diagnostic and therapeutic services	325,307	309,443
Promotion, prevention and protection services	7,886	7,517
Research and education	6,106	4,132
Administration (Note 8)	58,950	57,042
Information technology	385	469
Support services (Note 9)	113,808	105,027
Total allocated expenses	$ 2,166,269	$ 2,018,260

Note 11 Cash and Cash Equivalents

	March 31, 2013	March 31, 2012	April 1, 2011
Cash	$ 165,602	$ 553,703	$ 509,980
Money market securities < 90 days	519,002	258,823	614,132
Total cash and cash equivalents	$ 684,604	$ 812,526	$ 1,124,112

Cash and cash equivalents include money market securities which are comprised of Government of Canada treasury bills maturing June 2013 and bearing interest at an average yield of 0.95% at March 31, 2013 (March 31, 2012 – 0.94%; April 1, 2011 – 0.72%).

Included in cash and cash equivalents are $134,985 (March 31, 2012 - $459,418, April 1, 2011 - $329,979) that are segregated from other cash and cash equivalents and are intended to be used for specified purposes set out in their related agreements.

Cash and cash equivalents are readily convertible to known amounts of cash and that are subject to an insignificant risk of change in value. The fair values of cash and cash equivalents are estimated to approximate their carrying values because of their short-term nature.

Note 12 Portfolio Investments

	March 31, 2013		March 31, 2012		April 1, 2011	
	Fair Value	Cost	Fair Value	Cost	Fair Value	Cost
Money market securities > 90 days	$ 63,192	$ 63,192	$ 104,044	$ 104,044	$ 26,500	$ 26,500
Fixed income securities	1,138,744	1,128,522	1,348,967	1,339,076	1,276,987	1,285,322
Equities	213,287	188,127	103,235	93,988	102,559	88,344
Total portfolio investments	$ 1,415,223	$ 1,379,841	$ 1,556,246	$ 1,537,108	$ 1,406,046	$ 1,400,166

At March 31, 2012, $1,411,626 (April 1, 2011 - $1,244,338) of investments were classified as available for sale and $144,620 (April 1, 2011 - $161,708) of investments were classified as held for trading. Available for sale and held for trading classifications do not exist under PSAS.

Effective April 1, 2012, portfolio investments are measured at fair value with the differences between cost and fair value being recorded as a remeasurement gain or loss. The following are the net remeasurement gains on portfolio investments:

	March 31, 2013
Unrestricted unrealized net gains recorded in the Consolidated Statement of Accumulated Remeasurement Gains and Losses	$ 10,221
Restricted unrealized net gains attributable to endowments and recorded in deferred operating revenue (Note 17)	9,105
Restricted unrealized net gains attributable to and recorded in:	
Deferred operating revenue (Note 17)	7,741
Deferred capital revenue (Note 17)	4,161
Accounts payable and accrued liabilities (Note 15)	4,154
	$ 35,382

Note 12 **Portfolio Investments (continued)**

The data used to measure the fair value of AHS's portfolio investments falls under Level 1 - $213,287 and Level 2 - $1,201,936 of the fair value hierarchy. There were no transfers between levels during the current year or comparative years.

Included in the portfolio investments are $236,770 (March 31, 2012 - $212,050, April 1, 2011 - $204,214) that are segregated from other portfolio investments and are intended to be used for specified purposes set out in their related agreements.

As AHS is made up of multiple entities as described in Note 3(a), portfolio investments are governed independently under multiple investment policies and procedures. The fair value of portfolio investments governed under each investment policy is as follows:

	March 31, 2013	March 31, 2012	April 1, 2011
AHS Investment Bylaw	$ 1,138,667	$ 1,314,639	$ 1,175,666
ACF Investment Policy	109,002	96,987	90,436
LPIP Investment Policy	96,413	74,248	73,051
CHT Statement of Investment Policies and Goals	71,141	70,372	66,893
	$ 1,415,223	$ 1,556,246	$ 1,406,046

(a) Market Risk

Market risk is the risk of adverse financial impact as a consequent of market movements such as interest rates, currency rates and other price changes.

In order to earn financial returns at an acceptable level of market risk, each of the investment policies have established a maximum asset mix. The AHS Investment Bylaw has established maximum asset mix ranges of 0% to 100% for cash and money market securities, 0% to 80% for fixed income securities, and 0% to 40% for equities.

The ACF Investment Policy has established maximum asset mix policy of 0% to 10% for money market securities, 30% to 60% for fixed income securities, and 30% to 70% for equities. The LPIP Investment Policy has established maximum asset mix ranges of 80% to 87% for cash and fixed income securities, 10% to 15% for equities, and 3% to 5% for real estate. The CHT Statement of Investment Policies and Goals has established maximum asset mix policy of 30% to 70% for fixed income securities, and 30% to 70% for equities. Risk is reduced under all of the investment policies through asset class diversification, diversification within each asset class, and portfolio quality constraints.

A 10% change in market value relating to equity securities would have increased or decreased fair value by approximately $21,187 (2012 - $10,323).

(b) Interest Rate Risk

Interest rate risk is the risk that the value of a financial instrument might be adversely affected by a change in the market interest rates. Changes in market interest rates may have an effect on the cash flows associated with some financial assets and liabilities, known as cash flow risk, and on the fair value of other financial assets or liabilities, known as price risk. AHS manages the interest rate risk exposure of its fixed income investments by management of average duration and laddered maturity dates.

AHS is exposed to interest rate risk through its investments in debt securities with both fixed and floating interest rates.

A 1% change in market yield relating to fixed income debt securities would have increased or decreased fair value by approximately $34,661 (2012 - $56,410).

Note 12 **Portfolio Investments (continued)**

Portfolio investments include fixed income securities, such as bonds, and have an average effective yield of 1.79% (March 31, 2012 – 1.78%; April 1, 2011 – 2.60%) per year, maturing between 2013 and 2044. The securities have the following average maturity structure:

	March 31, 2013	March 31, 2012	April 1, 2011
1 – 5 years	81%	85%	86%
6 – 10 years	17%	12%	11%
Over 10 years	2%	3%	3%

(c) Foreign Currency Risk

Foreign currency risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates. The fair value of investments denominated in foreign currencies is translated into Canadian dollars using the reporting date exchange rate. AHS is exposed to foreign exchange fluctuations on its investments denominated in foreign currencies. However, this risk is managed by the fact that the investment policies limit non-Canadian equities to a maximum of 10% to 45% of the total investment portfolio, depending on the policy. As at March 31, 2013, investments in non-Canadian equities represented 1.58% (March 31, 2012 – 1.15%; April 1, 2011 – 0.98%) of total portfolio investments.

(d) Credit Risk

Credit risk is the risk of loss arising from the failure of a counterparty to fully honor its financial obligations. The credit quality of financial assets is generally assessed by reference to external credit ratings. Credit risk can also lead to losses when issuers and debtors are downgraded by credit rating agencies. All of the investment policies restrict the types and proportions of eligible investments, thus mitigating AHS's overall exposure to credit risk.

Under the AHS Investment Bylaw money market securities are limited to a rating of R1 or equivalent or higher and no more than 10% may be invested in any one issuer. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher and no more than 40% of the total fixed income securities. Investments in debt and equity of any one issuer are limited to 5% of the issuer's total debt and equity. Short selling is not permitted.

The ACF Investment Policy limits the overall rating of all fixed income instruments to at least an A rating, and no more than 10% of publically traded equities may be invested in any one issuer.

The LPIP Investment Policy limits money market securities to a rating of R1 or equivalent or higher and no more than 10% may be invested in any one issuer unless guaranteed by the Government of Canada or a Canadian province. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher. Investments in debt and equity of any one issuer are limited to 10% of total equities.

The CHT Statement of Investment Policies and Goals limits the overall rating of fixed income securities to BBB or equivalent or higher and no more than 10% of fixed income securities or equities may be invested in any one issuer.

(e) Liquidity Risk

Liquidity risk is the risk that AHS will encounter difficulty in meeting obligations associated with financial liabilities that are settled by delivery of cash or another financial asset. Liquidity requirements of AHS are met through funding in advance by AH, income generated from investments, and by investing in liquid assets, such as money market investments, equities and bonds, traded in an active market that are easily sold and converted to cash.

Note 13 **Accounts Receivable**

	March 31, 2013			March 31, 2012	April 1, 2011
	Gross Amount	Allowance for Doubtful Accounts	Net Realizable Value	Net Realizable Value	Net Realizable Value
Patient accounts receivable	$ 118,484	$ 31,936	$ 86,548	$ 121,922	$ 132,099
AH operating grants receivable	99,109	-	99,109	78,253	200,313
AH capital grants receivable	2,650	-	2,650	2,293	11,476
Other operating grants receivable	19,183	-	19,183	35,049	18,169
Other capital grants receivable	97,956	-	97,956	92,175	76,937
Other accounts receivable	58,623	648	57,975	83,808	56,398
	$ 396,005	$ 32,584	$ 363,421	$ 413,500	$ 495,392

Accounts receivable are unsecured and non-interest bearing. At March 31, 2012, the allowance for doubtful accounts was $31,899 (April 1, 2011 - $21,217).

Note 14 **Tangible Capital Assets**

Historical cost	March 31, 2012	Additions(a)	Transfers for work-in-progress	Disposals and write-downs(b)	March 31, 2013
Facilities and improvements	$ 6,138,968	$ -	$ 1,809,005	$ (10,379)	$ 7,937,594
Work in progress	2,109,881	579,612	(2,001,736)	-	687,757
Equipment	1,898,642	225,360	44,954	(55,540)	2,113,416
Information systems	932,565	28,907	99,361	(13)	1,060,820
Building service equipment	381,646	-	44,294	-	425,940
Land	109,429	-	15	-	109,444
Leased facilities and improvements	165,013	-	1,220	-	166,233
Land improvements	64,753	-	2,887	-	67,640
	$ 11,800,897	$ 833,879	$ -	$ (65,932)	$ 12,568,844

Accumulated amortization	March 31, 2012	Amortization expense	Effect of transfers	Effect of disposals and write-downs(b)	March 31, 2013
Facilities and improvements	$ 2,293,008	$ 212,266	$ -	$ (7,902)	$ 2,497,372
Work in progress	-	-	-	-	-
Equipment	1,282,031	160,820	-	(52,743)	1,390,108
Information systems	646,573	115,318	-	(13)	761,878
Building service equipment	216,804	24,418	-	-	241,222
Land	-	-	-	-	-
Leased facilities and improvements	97,007	12,596	-	-	109,603
Land improvements	50,303	2,476	-	-	52,779
	$ 4,585,726	$ 527,894	$ -	$ (60,658)	$ 5,052,962

Historical cost	April 1, 2011	Additions(a)	Transfers for work-in-progress	Disposals and write-downs(b)	March 31, 2012
Facilities and improvements	$ 6,001,128	$ -	$ 137,840	$ -	$ 6,138,968
Work in progress	1,669,214	776,256	(335,589)	-	2,109,881
Equipment	1,740,143	184,010	7,261	(32,772)	1,898,642
Information systems	757,329	21,379	154,546	(689)	932,565
Building service equipment	349,066	-	32,580	-	381,646
Land	108,830	599	-	-	109,429
Leased facilities and improvements	162,892	-	2,121	-	165,013
Land improvements	63,512	-	1,241	-	64,753
	$ 10,852,114	$ 982,244	$ -	$ (33,461)	$ 11,800,897

Accumulated amortization	April 1, 2011	Amortization expense	Effect of transfers	Effect of disposals and write-downs(b)	March 31, 2012
Facilities and improvements	$ 2,118,659	$ 174,349	$ -	$ -	$ 2,293,008
Work in progress	-	-	-	-	-
Equipment	1,160,474	151,775	-	(30,218)	1,282,031
Information systems	541,302	105,701	-	(430)	646,573
Building service equipment	194,307	22,497	-	-	216,804
Land	-	-	-	-	-
Leased facilities and improvements	81,900	15,107	-	-	97,007
Land improvements	48,008	2,295	-	-	50,303
	$ 4,144,650	$ 471,724	$ -	$ (30,648)	$ 4,585,726

Note 14 Tangible Capital Assets (continued)

	Net Book Value		
	March 31, 2013	March 31, 2012	April 1, 2011
Facilities and improvements	$ 5,440,222	$ 3,845,960	$ 3,882,469
Work in progress	687,757	2,109,881	1,669,214
Equipment	723,308	616,611	579,669
Information systems	298,942	285,992	216,027
Building service equipment	184,718	164,842	154,759
Land	109,444	109,429	108,830
Leased facilities and improvements	56,630	68,006	80,992
Land improvements	14,861	14,450	15,504
	$ 7,515,882	$ 7,215,171	$ 6,707,464

(a) Transferred Tangible Capital Assets

Additions include non-cash work in progress totaling $293,041 (2012 - $495,328) transferred from AI to AHS.

(b) Disposals and Write-Downs

Disposals include a write-down of information systems at a cost of $nil (2012 - $566) with an effect to accumulated amortization of $nil (2012 - $305).

(c) Leased Land

Land at the following sites has been leased to AHS at nominal values:

Site	Leased from	Lease expiry
Cross Cancer Institute Parkade	University of Alberta	2019
Banff Health Unit	Covenant Health	2028
Evansburg Community Health Centre	Yellowhead County	2031
Two Hills Helipad	Stella Stefiuk	2041
Northeast Community Health Centre	City of Edmonton	2046
Foothills Medical Centre Parkade	University of Calgary	2054
McConnell Place North	City of Edmonton	2056
Alberta Children's Hospital	University of Calgary	2101

(d) Leased Equipment

Equipment includes assets acquired through capital leases at a cost of $24,728 (2012 - $11,496) with accumulated amortization of $12,000 (2012 - $10,721). Equipment additions for the year ended March 31, 2013 include vehicle capital leases totaling $13,489 (2012 - $nil).

(e) Capitalized Interest

Total capitalized interest for the year ended March 31, 2013 was $3,489 (2012 - $16,605).

(f) Tangible Capital Assets Operated by Contracted Health Service Providers

As at March 31, 2013, the net book value of tangible capital assets owned by AHS but operated by a voluntary or private health service provider was $179,343 (2012 - $183,872; April 1, 2011 - $185,510).

Note 15 Accounts Payable and Accrued Liabilities

	March 31, 2013	March 31, 2012	April 1, 2011
Payroll remittances payable and accrued liabilities	$ 553,181	$ 546,331	$ 461,573
Trade accounts payable and accrued liabilities[a]	456,154	652,034	675,442
Provision for unpaid claims[b]	102,774	101,619	76,802
Other liabilities	41,661	48,599	70,615
	1,153,770	1,348,583	1,284,432
Unrealized net gains on portfolio investments related to accounts payable and accrued liabilities (Note 12)	4,154	-	-
	$ 1,157,924	$ 1,348,583	$ 1,284,432

(a) Capital Transactions

Trade accounts payable and accrued liabilities includes payables related to capital transactions of $142,634 (2012 - $243,234; April 1, 2011 - $224,366).

(b) Provision for Unpaid Claims

Provision for unpaid claims represents the losses from identified claims likely to be paid and provisions for liabilities incurred but not yet reported. The establishment of the provision for unpaid claims relies on the judgment and opinions of many individuals, on historical precedent and trends, on prevailing legal, economic, and social and regulatory trends, and on expectation as to future developments. The process of determining the provision necessarily involves risks that the actual results will deviate perhaps materially from the best estimates made.

Under accepted actuarial practice, the appropriate value of the claims liabilities is the discounted value of such liabilities plus the provision for adverse deviation. The provision for unpaid claims has been estimated using the discounted value of claim liabilities based on the expected market yield of the respective portfolio using a discount rate of 2.40% (2012 - 2.10%; April 1, 2011 - 3.25%).

Note 16 Employee Future Benefits

	March 31, 2013	March 31, 2012	April 1, 2011
Accrued vacation pay	$ 433,811	$ 428,146	$ 385,525
Accumulating non-vesting sick leave[a]	91,016	86,369	85,441
Registered defined benefit pension plans[b], [c]	-	-	-
	$ 524,827	$ 514,515	$ 470,966

(a) Accumulating non-vesting sick leave liability

The accumulating non-vesting sick leave liability is actuarially determined using the projected benefit method prorated on service and management's best estimates of expected discount rate, inflation, rate of compensation increase, termination and retirement rates and mortality. The liability associated with these benefits is calculated as the present value of expected future payments pro-rated for service based on actuarial valuation as at March 31, 2011 and projected for the periods ending March 31, 2012 and 2013. Any resulting net actuarial gain (loss) is deferred and amortized on a straight-line basis over the expected average remaining service life of the related employee groups.

Note 16 **Employee Future Benefits (continued)**

Sick leave benefits are paid by AHS; there are no employee contributions and no plan assets. The following table summarizes the accumulating non-vesting sick leave liability.

	March 31, 2013	March 31, 2012
Change in accrued benefit obligation and funded status		
Accrued benefit obligation and funded status, beginning of year	$ 96,558	$ 85,441
Current service cost	8,247	6,823
Interest cost	3,231	3,930
Benefits paid	(7,680)	(9,825)
Actuarial gain (loss)	(891)	10,189
Accrued benefit obligation and funded status, end of year	$ 99,465	$ 96,558
Reconciliation to accrued benefit liability		
Funded status - deficit	$ 99,465	$ 96,558
Unamortized net actuarial gain (loss)	(8,449)	(10,189)
Accrued benefit liability	$ 91,016	$ 86,369
Components of expense		
Current service cost	$ 8,247	$ 6,823
Interest cost	3,231	3,930
Amortization of net actuarial loss	849	-
Net expense	$ 12,327	$ 10,753
Assumptions		
Discount rate – beginning of period	3.20%	4.50%
Discount rate – end of period	3.30%	3.20%
Rate of compensation increase per year	2012-2013	2010-2011
	3.25%	3.25%
	2013-2014	2011-2012
	3.25%	3.25%
	Thereafter 3.25%	Thereafter 3.25%

(b) Local Authorities Pension Plan (LAPP)

(i) AHS Participation in the LAPP

The majority of AHS employees participate in the LAPP and as AHS is exposed to the risk of contribution rate increases, the following disclosure is provided to explain this risk.

The LAPP provides for a pension of 1.4% for each year of pensionable service based on the average salary of the highest five consecutive years up to the average Canada Pension Plan's Year's Maximum Pensionable Earnings (YMPE) over the same five consecutive year period and 2.0% on the excess, subject to the maximum pension benefit limit allowed under the *Income Tax Act* (Canada). The maximum pensionable service allowable under the plan is 35 years.

Note 16 **Employee Future Benefits (continued)**

The contribution rates were reviewed by the LAPP Board of Trustees in 2012 and are to be reviewed at least once every three years based on recommendations of the LAPP's actuary. AHS and its employees made the following contributions:

Calendar 2012		Calendar 2011	
Employer	**Employees**	**Employer**	**Employees**
$435,992	$398,564	$357,632	$324,613
9.91% of pensionable earnings up to the YMPE and 13.74% of the excess	8.91% of pensionable earnings up to the YMPE and 12.74% of the excess	9.49% of pensionable earnings up to the YMPE and 13.13% of the excess	8.49% of pensionable earnings up to the YMPE and 12.13% of the excess

AHS contributed $435,992 (2011 - $357,632) of the LAPP's total employer contributions of $1,012,225 from January 1, 2012 to December 31, 2012 (December 31, 2011 - $856,950).

(ii) LAPP Deficit

An actuarial valuation of the LAPP was carried out as at December 31, 2011 by Mercer (Canada) Limited and results were then extrapolated to December 31, 2012. LAPP's net assets available for benefits divided by LAPP's pension obligation shows that the LAPP is 82% (2011 - 81%) funded.

	December 31, 2012	December 31, 2011
LAPP net assets available for benefits	$ 22,862,497	$ 19,662,810
LAPP pension obligation	27,839,800	24,302,200
LAPP deficiency	$ (4,977,303)	$ (4,639,390)

Further information about the LAPP including assumptions and sensitivities of the LAPP's deficiency to changes in those assumptions can be found in the LAPP financial statements and the LAPP annual report.

The 2013 and 2014 LAPP contribution rates have been increased as follows:

Calendar 2014 (estimated)		Calendar 2013	
Employer	**Employees**	**Employer**	**Employees**
11.39% of pensionable earnings up to the YMPE and 15.84% of the excess	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess	10.43% of pensionable earnings up to the YMPE and 14.47% of the excess	9.43% of pensionable earnings up to the YMPE and 13.47% of the excess

(c) Management Employees Pension Plan (MEPP)

At December 31, 2012 the MEPP reported a deficiency of $303,423 (2011 - deficiency of $517,726).

Note 16 **Employee Future Benefits (continued)**

(d) Supplemental Executive Retirement Plans (SERPs)

As at March 31, 2013 an accrued benefit liability of $1,635 is included in accounts payable and accrued liabilities. As at March 31, 2012 and April 1, 2011 an accrued benefit asset is included in other assets (2012 - $8,519, April 1, 2011 - $5,952).

AHS sponsors SERPs which are funded and has three RCAs for these plans. Under the terms of the SERPs, participants will receive retirement benefits that supplement the benefits under AHS's registered plans that are limited by the *Income Tax Act* (Canada). As required under the plans' terms, any unfunded obligations identified in the actuarial valuation completed at the end of each fiscal year must be fully funded within 61 days. The accounting policies for SERPs are described in Note 3(g)(iii).

	March 31, 2013	March 31, 2012
Change in accrued benefit obligation		
Accrued benefit obligation, beginning of year	$ 35,185	$ 34,143
Change in actuarial assumption for discount rate (Note 2(b)(i))	9,632	-
Current service cost	492	1,774
Interest cost	1,219	1,704
Benefit payments	(2,333)	(1,956)
Decrease in obligation due to curtailment	-	(1,251)
Actuarial losses	514	771
Accrued benefit obligation, end of year	$ 44,709	$ 35,185
Change in plan assets		
Market value of plan assets, beginning of year	$ 43,704	$ 40,095
Change in valuation allowance	-	932
Actual return on plan assets	2,196	1,738
Actual employer contributions	15	2,895
Benefit payments	(2,333)	(1,956)
Market value of plan assets, end of year	$ 43,582	$ 43,704
Reconciliation of funded status to accrued benefit asset (liability)		
Funded status of the plan	$ (1,127)	$ 8,519
Unrecognized net actuarial losses	(508)	-
Accrued benefit asset (liability), end of year	$ (1,635)	$ 8,519

Note 16 **Employee Future Benefits (continued)**

Net actuarial gains or losses are amortized over a period of one year.

As a result of electing to use the exemption under PS 2125, AHS recognized a cumulative net actuarial loss of $5,921, cumulative initial obligations of $342, and cumulative past service costs of $296 in accumulated operating surplus as at April 1, 2011 (Note 2(b)(i)).

	March 31, 2013	March 31, 2012
Determination of net benefit cost		
Current period benefit cost	$ 492	$ 1,778
Amortization of actuarial losses (gains)	-	1,162
Interest cost on the accrued benefit obligation	1,219	1,704
Expected return on plan assets	(1,174)	(874)
Net benefit cost	$ 537	$ 3,770
Change in actuarial assumption for discount rate	$ 9,632	$ -
Members		
Active	44	51
Retired and terminated	54	52
Total members	98	103
Assumptions		
Weighted average discount rate to determine year end obligations	2.75%	4.80%
Weighted average discount rate to determine net benefit costs	2.75%	4.90%
Expected return on assets	2.75%	2.13%
Expected average remaining service life time	1	3
Rate of compensation increase per year	2012-2013	2011-2012
	0.00%	3.50%
	2013-2014	2012-2013
	0.00%	3.50%
	Thereafter	Thereafter
	0.00%	3.50%

(e) Pension expense

AHS's pension expense is recorded in salaries and benefits included in the Consolidated Schedules of Expenses by Object (Schedule 1). Additional disclosure of salaries and benefits is included in the Consolidated Schedules of Salaries and Benefits (Schedule 2).

	2013	2012
Local Authorities Pension Plan (LAPP)	$ 452,993	$ 361,575
Defined contribution pension plans and group RRSPs	42,208	29,976
Change in actuarial assumption for SERPs	9,632	-
Management Employees Pension Plan (MEPP)	722	661
Supplemental Pension Plan (SPPs)	2,127	523
Supplemental Executive Retirement Plans (SERPs)	537	3,770
Costs to transfer employees to LAPP	-	5,169
	$ 508,219	$ 401,674

Note 17 Deferred Revenue

	March 31, 2013	March 31, 2012	April 1, 2011
Unexpended deferred operating revenue(a)(d)	$ 483,953	$ 547,174	$ 712,377
Unexpended deferred capital revenue(b)(e)	240,358	383,171	557,562
Expended deferred capital revenue(c)	6,235,264	5,974,714	5,598,973
	$ 6,959,575	$ 6,905,059	$ 6,868,912

(a) Unexpended deferred operating revenue represents unspent resources with stipulations or external restrictions related to operating expenditures. Changes in the unexpended deferred operating revenue balance are as follows:

	March 31, 2013				March 31, 2012
	AH	Other government(i)	Donors and non-government	Total	Total
Balance, beginning of year	$ 282,915	$ 57,967	$ 206,292	$ 547,174	$ 712,377
Received or receivable during the year	1,002,196	38,611	167,844	1,208,651	907,092
Restricted investment income	1,072	1,867	6,254	9,193	8,582
Transferred from unexpended deferred capital revenue	9,498	32,147	11,310	52,955	7,422
Other transfers	-	-	-	-	(4,922)
Recognized as revenue	(1,077,695)	(105,445)	(167,726)	(1,350,866)	(1,083,377)
	217,986	25,147	223,974	467,107	547,174
Unrealized net gain on portfolio investments related to unexpended deferred operating revenue (Note 12)	4,237	437	12,172	16,846	-
Balance, end of year	$ 222,223	$ 25,584	$ 236,146	$ 483,953	$ 547,174

(i) The balance at March 31, 2013 for other government includes $1,264 of unexpended deferred operating revenue received from the federal government (March 31, 2012 - $885, April 1, 2011 - $nil).

Note 17 Deferred Revenue (continued)

(b) Unexpended deferred capital revenue represents unspent resources with stipulations or external restrictions related to the purchase of tangible capital assets. Changes in the unexpended deferred capital revenue balance are as follows:

	March 31, 2013				March 31, 2012
	AH	Other government	Donors and non-government	Total	Total
Balance, beginning of year	$ 193,571	$ 85,233	$ 104,367	$ 383,171	$ 557,562
Received or receivable during the year	76,399	129,513	49,924	255,836	151,904
Transferred tangible capital assets (Note14(a))	-	293,041	-	293,041	495,328
Restricted investment income	1,264	-	-	1,264	1,889
Unexpended deferred capital revenue returned	(1,332)	(2,239)	(4,717)	(8,288)	(97,200)
Transfer to expended deferred capital revenue	(114,577)	(457,058)	(64,222)	(635,857)	(718,291)
Transferred (to) unexpended deferred operating revenue	(9,498)	(32,147)	(11,310)	(52,955)	(7,422)
Used for the acquisition of land	-	(15)	-	(15)	(599)
	145,827	16,328	74,042	236,197	383,171
Unrealized net gain on portfolio investments related to unexpended deferred capital revenue (Note 12)	3,293	716	152	4,161	-
Balance, end of year	$ 149,120	$ 17,044	$ 74,194	$ 240,358	$ 383,171

(c) Expended deferred capital revenue at year-end represent external resources spent in the acquisition of tangible capital assets, stipulated for use in the provision of services over their useful lives. This revenue is recognized as revenue over the useful life of the assets. Changes in the expended deferred capital revenue balance are as follows:

	March 31, 2013				March 31, 2012
	AH	Other government	Donors and non-government	Total	Total
Balance, beginning of year	$ 427,473	$ 5,404,087	$ 143,154	$ 5,974,714	$ 5,598,973
Transferred from unexpended deferred capital revenue	114,577	457,058	64,222	635,857	718,291
Less amounts recognized as revenue	(106,688)	(239,125)	(29,494)	(375,307)	(342,550)
Balance, end of year	$ 435,362	$ 5,622,020	$ 177,882	$ 6,235,264	$ 5,974,714

Note 17 **Deferred Revenue (continued)**

(d) The unexpended deferred operating revenue balance at the end of the year is stipulated or externally restricted for the following purposes:

	March 31, 2013				March 31, 2012	April 1, 2011
	AH	Other government	Donors and non-government	Total	Total	Total
Research and education	$ 1,014	$ 1,455	$ 115,245	$ 117,714	$ 111,654	$ 104,642
Cancer prevention, screening and treatment	36,451	77	49,657	86,185	84,553	87,207
Primary Care Networks (Note 24)	56,845	-	78	56,923	42,646	41,946
Addiction and mental health	48,787	2,192	5	50,984	82,603	114,218
Physician revenue and Alternate Relationship Plans	36,019	-	19	36,038	28,380	54,116
Promotion, prevention and community	12,644	896	3,878	17,418	22,803	42,695
Inpatient acute nursing services	1,445	121	15,483	17,049	16,225	19,714
Administration and support services	326	3,581	5,999	9,906	14,991	12,137
Emergency and other outpatient services	4,493	106	4,442	9,041	12,833	21,049
Continuing care and seniors health	3,356	1,241	1,970	6,567	14,975	54,332
Diagnostic and therapeutic services	1,564	1,456	2,656	5,676	10,459	19,936
Information technology	5,354	25	182	5,561	3,607	15,369
Infrastructure maintenance	22	71	222	315	26,820	38,228
Virtual site training for Calgary South Health Campus	-	-	-	-	41,982	49,630
Others less than $10,000	9,666	13,926	24,138	47,730	32,643	37,158
	217,986	25,147	223,974	467,107	547,174	712,377
Unrealized net gain on portfolio investments related to unexpended deferred operating revenue (Note 12)	4,237	437	12,172	16,846	-	-
	$ 222,223	$ 25,584	$ 236,146	$ 483,953	$ 547,174	$ 712,377

Note 17 **Deferred Revenue (continued)**

(e) The unexpended deferred capital revenue balance at the end of the year is stipulated or externally restricted for the following purposes:

	March 31, 2013	March 31, 2012	April 1, 2011
AH			
Information systems:			
Regional Shared Health Information Program	$ 18,616	$ 34,540	$ 44,979
Access to Health Service IM IT	17,767	22,361	-
Diagnostic Imaging Project Year 6	11,339	-	-
Provincial Health Information Exchange	10,469	9,128	10,909
Diagnostic Imaging Project Years 2 & 3	3,886	25,844	29,004
Diagnostic Imaging Project Year 4	96	22,142	26,219
Others less than $10,000	61,979	48,887	75,971
	124,152	162,902	187,082
Medical Equipment Replacement Upgrade Program	10,305	-	-
Equipment less than $10,000	11,370	30,669	27,525
Total AH	145,827	193,571	214,607
Other government			
Facilities and improvements:			
Infrastructure maintenance projects	8,383	38,869	143,009
Others less than $10,000	7,945	43,691	114,470
Total other government	16,328	82,560	257,479
Donors and non-government			
North Treatment Centre	695	3,209	-
Stollery Paediatric Emergency Expansion	208	5,000	-
Equipment less than $10,000	64,847	97,747	56,663
Facilities and improvements less than $10,000	8,292	1,084	28,813
Total donors and non-government	74,042	107,040	85,476
	236,197	383,171	557,562
Unrealized net gain on portfolio investments related to unexpended deferred capital revenue (Note 12)	4,161	-	-
	$ 240,358	$ 383,171	$ 557,562

Note 18 Debt

	March 31, 2013	March 31, 2012	April 1, 2011
Debentures payable: [a]			
Parkade loan #1	$ 42,276	$ 44,528	$ 46,683
Parkade loan #2	38,637	40,510	42,303
Parkade loan #3	47,815	49,744	51,582
Parkade loan #4	172,674	178,292	15,000
Parkade loan #5	41,617	10,000	5,000
Calgary Laboratory Services purchase	3,472	10,179	16,583
Term loan-Parkade #4	-	-	138,000
Term loan-Parkade #5[b]	-	19,000	2,000
Obligation under leased tangible capital assets[c]	26,675	15,280	15,328
Other	2,218	2,446	3,820
	$ 375,384	$ 369,979	$ 336,299

(a) AHS issued debentures to Alberta Capital Financing Authority (ACFA), a related party, to finance the construction of parkades and the purchase of the remaining 50.01% ownership interest in CLS. AHS has pledged as security for these debentures revenue derived directly or indirectly from the operations of all parking facilities being built, renovated, owned and operated by AHS.

The maturity dates and interest rates for the debentures are as follows:

	Maturity Date	Fixed Interest Rate
Parkade loan #1	September 2026	4.4025%
Parkade loan #2	September 2027	4.3870%
Parkade loan #3	March 2029	4.9150%
Parkade loan #4	September 2031	4.9250%
Parkade loan #5	June 2032	4.2280%
Calgary Laboratory Services purchase	May 2013	4.6810%

(b) AHS obtained a term loan facility of $42,300 during 2011. In 2012, the term loan was replaced by the issuance of the balance of Parkade #5 debenture to ACFA of $32,300.

(c) The leased tangible capital assets include a site lease with the University of Calgary and vehicle leases.

The University of Calgary lease expires January 2028. The implicit interest rate payable on this lease is 6.50%. There are no renewal options, purchase options or escalation clauses related to this leased tangible capital asset.

AHS is contractually committed to future capital lease payments for vehicles until 2017. The implicit interest rate payable on these leases is 1.90%.

(d) As at March 31, 2013 AHS held a $220,000 revolving demand facility with a Canadian chartered bank which may be used for operating purposes. Draws on the facility bear interest at the bank's prime rate less 0.50% per annum. As at March 31, 2013, AHS has no draws against this facility.

AHS also holds a $33,000 revolving demand letter of credit facility which may be used to secure AHS's obligations to third parties relating to construction projects. As at March 31, 2013, AHS had $4,585 (March 31, 2012 - $5,353; April 1, 2011 $6,024) in letters of credit outstanding against this facility.

Note 18 Debt (continued)

AHS is committed to making payments as follows:

Year ended March 31	Debentures Payable, Term/Other Loan and Mortgages Payable Principal payments	Leased Tangible Capital Assets Minimum lease payments
2014	$ 17,249	$ 5,324
2015	18,004	4,640
2016	14,091	4,486
2017	15,943	4,486
2018	14,372	1,465
Thereafter	269,050	15,381
	$ 348,709	35,782
Less: interest		(9,107)
		$ 26,675

During the year, the amount of interest expensed was $14,480 (2012 - $9,009), of which loan interest was $13,047 (2012 - $8,068) and other interest charges was $1,433 (2012 - $941).

Note 19 Accumulated Operating Surplus

	Unrestricted net assets (deficiency)	Reserves for future purposes [a]	Net assets invested in tangible capital assets[a]	Accumulated operating surplus
Balance as at April 1, 2011	$ 10,195	$ 97,647	$ 776,982	$ 884,824
Operating surplus	86,899	-	-	86,899
Tangible capital assets purchased with internal funds	(219,655)	-	219,655	-
Amortization of internally funded tangible capital assets	131,987	-	(131,987)	-
Repayment of debt used to fund tangible capital assets	(10,655)	-	10,655	-
Net repayment of life lease deposits	(451)	-	451	-
Transfer of revenue for acquisition of land	(599)	-	599	-
Transfer of reserves for future purposes	(1,134)	1,134	-	-
Balance as at March 31, 2012	(3,413)	98,781	876,355	971,723
Operating surplus	106,391	-	-	106,391
Tangible capital assets purchased with internal funds	(182,394)	-	182,394	-
Amortization of internally funded tangible capital assets	157,861	-	(157,861)	-
Repayment of debt used to fund tangible capital assets	(16,224)	-	16,224	-
Net receipt of life lease deposits	563	-	(563)	-
Transfer of revenue for acquisition of land	(15)	-	15	-
Transfer of reserves for future purposes	20,054	(20,054)	-	-
Balance as at March 31, 2013	$ 82,823	$ 78,727	$ 916,564	$ 1,078,114

Note 19 Accumulated Operating Surplus (continued)

(a) Reserves

The AHS Board has approved the restriction of net assets for future purposes as follows:

	March 31, 2013	March 31, 2012	April 1, 2011
South Health Campus (i)	$ 16,444	$ 45,016	$ 50,000
Cancer research reserve (ii)	17,289	17,324	18,710
Parkade infrastructure reserve (iii)	32,745	24,522	16,722
Specific local initiatives reserve (iv)	11,919	11,919	12,215
Retail food services infrastructure reserve(v)	330	-	-
Reserves for future purposes	78,727	98,781	97,647
Net assets invested in tangible capital assets(vi)	916,564	876,355	776,982
	$ 995,291	$ 975,136	$ 874,629

(i) Restriction of operating net assets to assist with funding start up costs for South Health Campus in Calgary.
(ii) Restriction of operating net assets to fund cancer research.
(iii) Restriction of parking services surpluses to establish a parking infrastructure reserve for future major maintenance, upgrades, and construction.
(iv) Restriction of operating net assets for specific local initiatives as a result of local fundraising.
(v) Restriction of retail food services surplus to assist with future upgrades, maintenance, equipment, and construction costs for retail food service operations.
(vi) Restriction of net assets equal to the net book value of internally funded tangible capital assets as these net assets are not available for any other purpose.

Note 20 Accumulated Unrealized Net Gains

	March 31, 2013	March 31, 2012
Balance, beginning of year	$ 18,252	$ 3,332
Adjustment on adoption of the financial instrument standard (Note 2(c)(v)) resulting in a transfers of unrealized gains to:		
Deferred revenue	(10,837)	-
Consolidated Statement of Accumulated Remeasurement Gains and Losses	(5,272)	-
Accounts payable and accrued liabilities	(2,143)	-
Net unrealized gains arising during the year on available for sale financial assets	-	25,124
Transfer of net realized gains on investments to revenue	-	(10,204)
Balance, end of year	$ -	$ 18,252

Note 21 Endowments

	March 31, 2013	March 31, 2012
Balance, beginning of year	$ 63,740	$ 59,773
Endowments received or receivable	1,467	3,967
Balance, end of year	$ 65,207	$ 63,740

Note 22 Contractual Obligations and Contingent Liabilities

(a) Leases

AHS is contractually committed to future operating lease payments for premises until 2033 as follows:

Year ended March 31		Total lease payments
2014	$	53,709
2015		49,159
2016		43,499
2017		39,320
2018		29,496
Thereafter		88,066
	$	303,249

(b) Tangible Capital Assets

AHS has the following outstanding contractual commitments for purchases of tangible capital assets as at March 31:

		2013
Facilities and improvements	$	59,136
Equipment		44,195
Information systems		43,915
	$	147,246

(c) Contracted Health Service Providers

AHS contracts on an ongoing basis with voluntary and private health service providers to provide health services in Alberta as disclosed in Note 10. AHS has contracted for services in the year ending March 31, 2014 similar to those provided by these providers in 2012-13.

(d) Contingent Liabilities

AHS is subject to legal claims during its normal course of business. AHS records a liability when the assessment of a claim indicates that a future event is likely to confirm that an asset had been impaired or a liability incurred at the date of the financial statements and the amount of the contingent loss can be reasonably estimated.

Accruals have been made in specific instances where it is likely that losses will be incurred based on a reasonable estimate. As at March 31, 2013, accruals have been recorded as part of the provision for unpaid claims (Note 15). Included in this accrual are claims in which the AHS has been jointly named with the Minister. The accrual provided for these claims under the provision for unpaid claims represents AHS's portion of the liability.

At March 31, 2013, AHS has been named in 187 legal claims (2012 - 158 claims) where the occurrence of a future event confirming a contingent loss is not reasonably determinable. Of these, 172 claims have $317,929 in specified amounts and 15 have no specified amounts (2012 - 137 claims with $234,873 of specified claims and 21 claims with no specified amounts). The resolution of indeterminable claims may result in a liability, if any, that may be significantly lower than the claimed amount.

Alberta Health Services has been named as a co-defendant, along with the Government of Alberta, in a certified Class Action with regard to increased long-term accommodation charges, which were increased by a Cabinet order effective August 1, 2003. The amount of the Claim has not yet been specified, but it has been estimated to be between $100,000 and $175,000 per year, based on the amount of the August 1, 2003 increases in accommodation charges.

Note 23 **Related Parties**

Transactions with the following related parties are considered to be in the normal course of operations. Amounts due to or from the related parties and the recorded amounts of the transactions are included within these consolidated financial statements, unless otherwise stated.

The Minister of Health controls the AHS Board by appointing all its members. The viability of AHS's operations depends on transfers from the Ministry. Transactions between AHS and AH are reported and disclosed in the Consolidated Statements of Operations, the Consolidated Statements of Financial Position, and the Notes to the Consolidated Financial Statements, and are therefore excluded from the table below.

AHS shares a common relationship and is considered to be a related party with those entities consolidated or included on a modified equity basis in the GOA consolidated financial statements. Transactions in the normal course of operations between AHS and the other ministries are recorded at their exchange amount as follows:

	Revenue		Expenses	
	2013	2012	2013	2012
Ministry of Enterprise and Advanced Education (i)	$ 41,138	$ 50,759	$ 124,899	$ 135,023
Ministry of Infrastructure (ii)	66,888	42,218	137	16
Other ministries	39,401	47,225	25,884	24,571
Total for the year	$ 147,427	$ 140,202	$ 150,920	$ 159,610

	Receivable from		Payable to	
	2013	2012	2013	2012
Ministry of Enterprise and Advanced Education (i)	$ 16,731	$ 37,039	$ 24,425	$ 21,714
Ministry of Infrastructure (ii)	40,292	61,886	-	151,248
Other ministries (iii)	3,859	5,976	351,514	338,571
Balance, end of year	$ 60,882	$ 104,901	$ 375,939	$ 511,533

(i) Most of AHS transactions with the Ministry of Enterprise and Advanced Education relate to initiatives with the University of Alberta and the University of Calgary. These initiatives include teaching, research, and program delivery. A number of physicians are employed by either AHS or the universities but perform services for both. Due to proximity of locations, some initiatives result in sharing physical space and support services. The revenue and expense transactions are a result of grants provided from one to the other and recoveries of shared costs.

(ii) The transactions with the Ministry of Infrastructure relate to the construction and funding of tangible capital assets (Note 14).

(iii) The payable transactions with other ministries include the debt payable to ACFA.

At March 31, 2013 AHS has recorded at the exchange amount deferred revenue from other ministries within the GOA of $24,320 (March 31, 2012 - $57,082) related to unexpended deferred operating revenue, $17,044 (March 31, 2012 - $85,233) related to unexpended deferred capital revenue and $5,622,020 (March 31, 2012 - $5,404,087) related to expended deferred capital revenue.

Outstanding contingencies in which AHS has been jointly named with other government entities within the GOA are disclosed in Note 22(d).

Note 24 Government Partnerships

The following is 100% of the financial position and results of operations for AHS's government partnerships with PCNs, NACTRC and HUTV. AHS has proportionately consolidated 50% of the results of the PCNs and NACTRC and 30% of HUTV.

	March 31, 2013	March 31, 2012	April 1, 2011
Total assets	$ 123,786	$ 105,329	$ 95,000
Total liabilities	123,786	105,329	95,000
Net assets	$ -	$ -	$ -
Total revenue	$ 146,480	$ 149,380	
Total expenses	146,480	149,380	
Net operating surplus	$ -	$ -	

As a requirement of AH, PCNs can only use accumulated operating surpluses based on an approved surplus reduction plan; therefore, AHS's proportionate share of these surpluses has been recorded by AHS as deferred revenue, and are reflected as liabilities in the above table.

Note 25 Trusts

(a) Trust Funds

AHS receives funds in trust for research and development, education, and other programs. These amounts are held and administered on behalf of others in accordance with the terms and conditions embodied in the relevant agreements with no unilateral power to change the conditions set out in the trust indenture (or agreement) and therefore are not reported in these consolidated financial statements. As at March 31, 2013, the balance of funds held in trust by AHS for research and development is $8,443 (2012 - $9,267).

AHS also receives funds in trust from continuing care residents for personal expenses. These amounts are not included above and not consolidated in these financial statements.

(b) Health Benefit Trust of Alberta (HBTA)

AHS is one of more than 30 participants in the HBTA and has a majority of representation on the HBTA governance board. The HBTA is a formal health and welfare trust established under a Trust Agreement effective January 1, 2000. The HBTA provides health and other related employee benefits pursuant to the authorizing Trust Agreement. The HBTA uses various carriers for the different benefits.

The HBTA maintains various reserves to adequately provide for all current obligations and reported fund balances of $79,394 as at December 31, 2012 ($57,081 as at December 31, 2011; $79,576 as at December 31, 2010). Under the terms of the Trust Agreement, no participating employer or eligible employee shall have any right to any surplus or assets of the Trust nor shall they be responsible for any deficits or liabilities of the Trust. However, AHS has included in prepaid expenses $57,759 (March 31, 2012 - $41,494; April 1, 2011 - $44,118) as a share of the HBTA's fund balances representing in substance a prepayment of future contributions. For the period January 1 to December 31, 2012 AHS paid premiums of $277,894 (2011 - $232,162).

Note 26 Approval of Consolidated Financial Statements

The consolidated financial statements were approved by the AHS Board on June 6, 2013.

SCHEDULE 1 - CONSOLIDATED SCHEDULES OF EXPENSES BY OBJECT
YEARS ENDED MARCH 31

	2013		2012
	Budget (Note 4) (Schedule 3)	Actual	Actual (Note 2) (Schedule 4)
Salaries and benefits (Schedule 2)	$ 6,851,000	$ 6,752,659	$ 6,161,025
Contracts with health service providers (Note 10)	2,265,000	2,166,269	2,018,260
Contracts under the Health Care Protection Act	21,000	16,852	18,434
Drugs and gases	386,000	388,013	387,984
Medical and surgical supplies	354,000	391,649	360,002
Other contracted services	1,148,000	1,099,199	1,055,932
Other [(a)]	1,191,000	1,220,403	1,270,986
Amortization, disposals and write-downs (Note 14)	521,000	533,168	474,537
	$ 12,737,000	$ 12,568,212	$ 11,747,160

(a) Significant amounts included in Other are:	2013 Actual	2012 Actual
Equipment expense	$ 152,472	$ 152,498
Other clinical supplies	140,350	140,848
Building and ground expenses	116,530	109,941
Building rent	115,712	112,334
Utilities	109,362	108,354
Housekeeping, laundry and linen, plant maintenance and biomedical engineering supplies	82,497	84,465
Minor equipment purchases	75,864	104,019
Food and dietary supplies	68,080	68,495
Telecommunications	53,862	50,375
Office supplies	52,804	65,474
Travel	49,140	49,719
Fundraising and grants awarded	45,826	50,359
Insurance	23,788	42,670
Licenses, fees and membership	17,876	15,453
Education	13,903	16,470
Other	102,337	99,512
	$ 1,220,403	$ 1,270,986

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2013

	2013								2012	
						Severance [e]				
	FTE[a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Number of Individuals	Amount	Total	FTE* [a]	Total* (Note 2)
Total Board (Sub-Schedule 2A)	13.95	$ -	$ 593	$ -	$ 593	-	$ -	$ 593	13.70	$ 701
Total Executive (Sub-Schedule 2B)	11.16	4,031	857	706	5,594	-	-	5,594	9.71	6,309
Management Reporting to CEO Reports	38.33	6,632	505	1,522	8,659	1	26	8,685	35.81	13,502
Other Management	3,270.96	370,902	8,635	80,582	460,119	20	1,006	461,125	3,211.57	434,680
Medical Doctors not included above	123.10	33,822	668	2,216	36,706	-	-	36,706	137.75	40,254
Regulated nurses not included above:										
RNs, Reg. Psych. Nurses, Grad Nurses	18,044.91	1,574,565	246,401	329,514	2,150,480	22	605	2,151,085	17,524.41	1,989,737
LPNs	3,869.85	227,595	35,716	45,852	309,163	3	88	309,251	3,679.70	290,310
Other Health Technical & Professionals	13,814.16	1,123,362	85,298	268,111	1,476,771	16	442	1,477,213	14,333.33	1,409,885
Unregulated Health Service Providers	7,422.79	346,061	50,213	73,889	470,163	5	119	470,282	6,520.12	395,228
Other Staff	25,659.51	1,440,380	71,089	306,725	1,818,194	87	4,299	1,822,493	23,519.78	1,575,250
Change in actuarial assumption for discount rate for SERPs	-	-	-	9,632	9,632	-	-	9,632	-	-
Costs to transfer employees to LAPP	-	-	-	-	-	-	-	-	-	5,169
Total	72,268.72	$ 5,127,350	$ 499,975	$ 1,118,749	$ 6,746,074	154	$ 6,585	$ 6,752,659	68,985.88	$ 6,161,025

*Certain 2012 amounts have been reclassified to conform to the 2013 presentation.

The accompanying footnotes and sub-schedules are part of this schedule.

SUB-SCHEDULE 2A - BOARD HONORARIA FOR THE YEAR ENDED MARCH 31, 2013

	Term	2013 Committees	2013 Honoraria	2012 Honoraria
Board Chair				
Stephen Lockwood[f]	Since Oct 13, 2010	AF, GOV, HA, HR, QS[m]	$ 75	$ 52
Catherine Roozen[g]	Since Jul 29, 2008	AF, GOV, HA, HR, QS[m]	35	60
Ken Hughes[h]	May 15, 2008 to Dec 28, 2011	-	-	63
Board Members				
Dr. Ray Block[i]	Feb 18, 2011 to Sep 20, 2012	AF, HR	24	38
Teri Lynn Bougie	Nov 20, 2008 to Mar 31, 2013	GOV, HA, QS	53	54
Dr. Ruth Collins-Nakai	Since Feb 18, 2011	HR, QS	56	53
Donald Cormack	Since Mar 5, 2013	-[n]	5	-
Dr. Kamalesh Gangopadhyay	Oct 13, 2010 to Mar 31, 2013	GOV, HA, QS	53	54
Don Johnson	Since Feb 18, 2011	AF, HA, PASC	55	56
John Lehners	Since May 15, 2008	HA, HR, PASC	55	56
Frederick Ring	Since Mar 5, 2013	-[n]	5	-
Gary Sciur	Since Mar 5, 2013	-[n]	4	-
Don Sieben[j]	Since May 15, 2008	AF, GOV, HA, HR, QS[m]	55	56
Dr. Eldon Smith	Since Feb 18, 2011	AF, GOV, QS	54	53
Sheila Weatherill[k]	Feb 18, 2011 to Aug 2, 2012	AF, GOV, HR, PASC	-	-
Gord Winkel	Nov 20, 2008 to Mar 31, 2013	HR, QS	56	54
Irene Lewis	May 15, 2008 to Mar 31, 2012	-	-	50
Board Committee Participants[l]				
Dr. Thomas Feasby	Jan 27, 2011 to Jun 30, 2012	QS	-	1
Dennis Hoffman	Since Feb 11, 2013	AF	2	-
Dr. Jon Meddings	Since Jul 1, 2012	QS	3	-
Dr. Douglas Miller	Since Jul 1, 2012	QS	2	-
Elaine Noel-Bentley	Since Jun 15, 2012	PASC	1	-
Dr. Verna Yiu[k]	Jun 21, 2011 to Jun 30, 2012	QS	-	-
Dr. Philip Baker	Jan 27, 2011 to Jun 17, 2011	-	-	1
Total Board			$ 593	$ 701

Board members are compensated with monthly honoraria and honoraria for attendance at board and committee meetings and all other AHS Board business up to a maximum limit in accordance with Ministerial Order #50. Although M.O. #50 was repealed by M.O. #93, original rates from M.O. #50 were adopted again as of January 1, 2010. Effective November 1, 2012, the Minister of Health clarified the rates for committee meeting attendance.

Committee legend: AF = Audit and Finance, GOV = Governance, HA = Health Advisory, HR = Human Resources, QS = Quality and Safety, PASC = Pension Advisory Sub-Committee

SUB-SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2013

	2013						
For the Current Fiscal Year	Base Salary [b]	Pay-at-Risk Component [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance [e]	Total
Board Direct Reports							
Dr. Chris Eagle – President and Chief Executive Officer (p,t,ee)	$ 580	$ 108	$ 41	$ 65	$ 794	$ -	$ 794
Ronda White – Chief Audit Executive (ff)	206	29	-	41	276	-	276
Noela Inions – Ethics and Compliance Officer (gg)	225	- (s)	-	60	285	-	285
Patti Grier – Chief of Staff and Corporate Secretary (u,gg)	192	29	-	33	254	-	254
CEO Direct Reports							
Chris Mazurkewich – Executive VP and Chief Operating Officer (p,hh)	468	93	22	64	647	-	647
Duncan Campbell – Executive VP and Chief Financial Officer (p,v,hh)	-	-	-	-	-	-	-
Allaudin Merali – Executive VP and Chief Financial Officer (p,w,hh,kk)	96	-	10	9	115	- (w)	115
Deborah Rhodes – Acting Chief Financial Officer (x,ff)	245	34	2	38	319	-	319
Dr. David Megran – Executive VP and Chief Medical Officer, Clinical Operations (p,r,y,ii)	485	98	46	176	805	-	805
Dr. Verna Yiu – Executive VP and Chief Medical Officer, Quality and Medical Affairs (p,q,z,jj)	316	52	36	22	426	-	426
Bill Trafford – Executive VP and Chief Development Officer (p,hh)	339	55	22	56	472	-	472
Stephen Gould – Executive VP, People and Partners (p,aa,hh)	411	69	32	68	580	-	580
Dr. Kathryn Todd – Senior VP, Research (q,bb,jj)	229	35	9	24	297	-	297
Barbara Pitts – Senior VP, Priorities and Performance (cc,gg)	156	23	-	35	214	-	214
Deb Gordon – Senior VP, Health Professions Strategy and Practice and Chief Nursing and Health Professions Officer (dd,gg)	83	12	-	15	110	-	110
Total Executive	$ 4,031	$ 637	$ 220	$ 706	$ 5,594	$ -	$ 5,594

SUB-SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2013 (CONTINUED)

	2012						
For the Prior Fiscal Year	Base Salary [b]	Pay-at-Risk Component [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance [e]	Total
Board Direct Reports							
Dr. Chris Eagle – President and Chief Executive Officer	$ 580	$ 88	$ 21	$ 232	$ 921	$ -	$ 921
Ronda White – Chief Audit Executive	200	24	-	43	267	-	267
Noela Inions – Ethics and Compliance Officer	209	16	-	51	276	-	276
CEO Direct Reports							
Chris Mazurkewich – Executive VP and Chief Operating Officer	345	45	19	89	498	-	498
Chris Mazurkewich – Executive VP and Chief Financial Officer	105	16	7	33	161	-	161
Deborah Rhodes – Acting Chief Financial Officer	128	19	1	27	175	-	175
Dr. David Megran – Executive VP and Chief Medical Officer	481	61	54	173	769	-	769
Dr. Francois Belanger – Acting Executive VP and Chief Medical Officer	66	-	-	-	66	-	66
Bill Trafford – Executive VP and Chief Development Officer	112	17	8	16	153	-	153
Stephen Gould – Executive VP, People and Partners	221	35	18	39	313	-	313
Mike Conroy – Acting Executive VP, People and Partners	185	29	14	48	276	-	276
Alison Tonge – Executive VP, Strategy and Performance (o)	288	45	37	49	419	392	811
Pam Whitnack – Executive VP, Rural, Public and Community Health	60	-	2	18	80	-	80
Andrew Will – Executive VP and Executive Lead Transition	335	58	58	78	529	738	1,267
Patti Grier – Chief of Staff for the AHS Board	179	27	1	58	265	-	265
Lynn Redford – Chief of Staff, Board Office and VP Community Engagement	10	-	-	1	11	-	11
Total Executive	$ 3,504	$ 480	$ 240	$ 955	$ 5,179	$ 1,130	$ 6,309

FOOTNOTES TO THE CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2013

Definitions

a. For this schedule, Full time equivalents (FTE) are determined by actual hours earned divided by 2,022.75 annual base hours. If applicable, FTE for Board Members are prorated using the number of days in the fiscal year between either the date of appointment and the end of the year or the beginning of the year and the termination date.

b. The compensation model for senior leaders includes a component that is at risk if they do not meet performance objectives.

Pay at risk: Eligible senior leaders participate in 'pay-at-risk'. Under this model, a component of remuneration is withheld during the year and released (in full or in part) based on achievement of performance objectives.

Vacation accruals are included in base salary except for direct reports of the Board or President and Chief Executive Officer where vacation payouts are included in other cash benefits and vacation accruals are included in other non-cash benefits.

c. Other cash benefits may include as applicable honoraria, overtime, automobile allowance, lump sum payments, an allowance for professional development and an allowance for personal, financial and tax advice, club memberships and other similar purposes. Relocation expenses are excluded from compensation disclosure as they are considered to be recruiting costs to AHS and not part of compensation. Expense reimbursements are also excluded from compensation disclosure except where the expenses meet the definition of the other cash benefits listed above. For anyone other than direct reports of the Board or the President and Chief Executive Officer, other cash benefits may also include pay at risk if applicable.

d. Other non-cash benefits include:

- Employer's current period benefit costs and other costs of supplemental pension plan and supplemental executive retirement plans as defined in Sub-Schedule 2C.
- Share of employee benefit contributions and payments made on behalf of employees including pension, health care, dental coverage, vision coverage, out-of-country medical benefits, group life insurance, accidental disability and dismemberment insurance, and long and short-term disability plans.
- Employer's share of the cost of additional benefits including sabbaticals or other special leave with pay.

e. Severance includes direct or indirect payments to individuals upon termination or through a voluntary exit program. Severance is not included in other cash benefits or non-cash benefits.

FOOTNOTES TO THE CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2013 (CONTINUED)

Board

f. Stephen Lockwood was appointed Board Chair on September 4, 2012.

g. Catherine Roozen was Board Vice Chair until being appointed Interim Board Chair from December 28, 2011 until September 4, 2012 at which time she resumed her role as Board Vice Chair.

h. Ken Hughes was Board Chair until December 28, 2011.

i. Dr. Ray Block started claiming honoraria on July 8, 2011.

j. Don Sieben was Interim Board Vice Chair from January 17, 2012 until September 4, 2012.

k. Sheila Weatherill and Dr. Verna Yiu did not claim honoraria.

l. These individuals are participants of Board committees, but are not Board members or AHS employees. However, they are eligible to receive honoraria for meetings attended.

m. Board Chair and Board Vice Chair, including interims, are Ex-Officio Members on all Committees.

n. Board members not appointed to committees until April 2, 2013.

Executive Remuneration

o. In the prior year, severance of $436 was accrued for the incumbent. However, the total severance payments to the incumbent totalled $392. Per the incumbent's contract, if alternate employment was found, the incumbent was only entitled to receive one-half of the remaining payments. Furthermore, the incumbent did not claim the maximum eligible legal fees. The prior year balance has been restated to reflect the actual severance paid.

p. Incumbents are provided with an automobile allowance. Dollar amounts are included in other cash benefits. No incumbents were provided with an automobile in the current year.

q. The incumbent is on secondment from the University of Alberta. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Alberta. AHS reimburses the University for the incumbent's base salary and benefits including annual performance adjustments. In lieu of enrollment into the AHS Supplementary Pension Plan (SPP), the incumbent will receive an annual lump sum supplemental payment equivalent to the amount the incumbent would have received as a member of the SPP and payable from AHS. This lump sum has been included in Other Cash Benefits.

r. The incumbent is on secondment from the University of Calgary. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Calgary. AHS reimburses the University for the incumbent's rank salary; all amounts have been included in base salary.

s. The incumbent is no longer eligible to receive pay-at-risk.

FOOTNOTES TO THE CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2013 (CONTINUED)

Changes to Executive

t. The incumbent held the position of President and Chief Executive Officer effective April 1, 2011. The contract term ends March 31, 2016.

u. The incumbent was a direct report to the President and Chief Executive Officer until September 13, 2012 at which time the incumbent became a direct report to the Board.

v. The incumbent held the position effective April 1, 2013.

w. The incumbent held the position effective May 7, 2012 until August 1, 2012 (calculated FTE of 0.24) at which time the incumbent left AHS. The incumbent did not receive any severance. The incumbent is disputing the non-payment of severance.

x. The incumbent held the position of Acting Chief Financial Officer until May 7, 2012 at which time the incumbent resumed the role of Senior Vice President Finance. The incumbent returned to the position of Acting Chief Financial Officer effective August 23, 2012. The incumbent received up to an additional 10% of base salary while in the Acting Chief Financial Officer position (calculated FTE of 0.70).

y. The incumbent held the position of Executive Vice President and Chief Medical Officer until August 13, 2012 at which time the position became two positions as a result of restructuring: Executive Vice President and Chief Medical Officer, Clinical Operations and Executive Vice President and Chief Medical Officer, Quality and Medical Affairs. Incumbent held the position Executive Vice President and Chief Medical Officer, Clinical Operations effective August 13, 2012. There was no change to compensation for the Executive Vice President and Chief Medical Officer, Clinical Operations position.

z. The incumbent held the position effective August 13, 2012 (calculated FTE of 0.63). The contract term ends August 13, 2017. This is a new position as a result of restructuring.

aa. The incumbent held the position effective September 19, 2011. The contract term ends September 18, 2016.

bb. The incumbent held the position effective May 1, 2012 (calculated FTE of 0.92). The contract term ends April 30, 2017. This is a new position as a result of restructuring.

cc. The incumbent held the position effective October 29, 2012 (calculated FTE of 0.42). This is a new position as a result of restructuring.

dd. The incumbent became a direct report to the President and Chief Executive Officer January 1, 2013 as a result of restructuring (calculated FTE of 0.25).

FOOTNOTES TO THE CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2013 (CONTINUED)

Executive Termination Liabilities

ee. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive a maximum severance pay for 12 months base salary at the rate in effect at the date of termination. The incumbent will also receive 15% of the severance in lieu of all other benefits.

ff. In the case of termination without just cause by AHS, the incumbent shall receive severance pay equal to 12 months base salary. This severance payment will be reduced by any employment earnings received from a new employer within the 12 month period.

gg. The incumbent's termination benefits have not been predetermined.

hh. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to 12 months base salary at the rate in effect at the date of termination. Such severance will be paid in 12 equal monthly installments. The incumbent will also be paid 15% of the severance in lieu of all other benefits. Upon obtaining alternate employment, the incumbent is only entitled to receive one-half of the unpaid severance at that time.

ii. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to a maximum of 18 months base salary(r) and premium payments at the rate in effect at the date of termination. The incumbent will also be paid an amount up to 18 months of the total cost of the incumbent's benefits. AHS will also make payment for the incumbent to attend an outplacement program for 6 months.

jj. There is no severance associated with the secondment agreement. Upon termination of the secondment agreement, the incumbent would return to the incumbent's regular position at the University of Alberta.

kk. SPP and SERP

Based on the provision of the applicable SPP and SERP, the following outlines the benefits received by individuals who terminated employment with AHS within the 2012-2013 fiscal period:

Position	Benefit (not in thousands)	Frequency	Payment Terms
Executive VP and Chief Financial Officer*	$13,552	Monthly	For the 4 months from September 1 until December 31, 2012
	$13,682	Monthly	From January 1, 2013, increasing every January 1 as a result of Cost of Living Adjustments. SERP expires March 1, 2019

*The incumbent receives SERP payments for his role at the former Capital Health. Payments were put on hold while the incumbent was the Executive Vice President and Chief Financial Officer for AHS and were resumed subsequent to his departure as per the original Capital Health contract. There was no change to the amount of future payments as a result of being employed by AHS.

SUB-SCHEDULE 2C - EXECUTIVE SUPPLEMENTAL PENSION PLAN AND SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN

Certain employees will receive retirement benefits that supplement the benefits limited under the registered plans for service post 1991. The Supplemental Pension Plan (SPP) is a defined contribution plan and the Supplemental Executive Retirement Plan (SERP) is a defined benefit plan. The SERP is disclosed in Notes 2(b)(i), 3(g)(iii) and 16(d). The amounts in this table represent the total SPP and SERP benefits earned by the individual during the fiscal year. The current period benefit costs for SPP and the current period benefits costs and other costs for SERP included in other non-cash benefits disclosed in Sub-Schedule 2B are prorated for the period of time the individual was in their position directly reporting to the Board and directly reporting to the President and Chief Executive Officer. The change for actuarial assumption for discount rate is not included in Sub-Schedule 2B as this does not represent benefits earned during the period.

	2013						2012
	SPP	SERP					
	Current period benefit costs(1)	Current period benefit costs(2)	Other Costs(3)	Included in Other Non-Cash Benefits	Change in actuarial assumption for discount rate	Total	Total
President and Chief Executive Officer – SPP (t)	$ 43	$ -	$ -	$ 43	$ -	$ 43	$ 44
President and Chief Executive Officer – SERP (t)	-	-	(2)	(2)	406	404	87
Chief Audit Executive	6	-	-	6	-	6	6
Ethics and Compliance Officer	8	-	-	8	-	8	7
Chief of Staff and Corporate Secretary (u)	4	-	-	4	-	4	5
Executive VP and Chief Operating Officer	32	-	-	32	-	32	30
Executive VP and Chief Financial Officer (v)	-	-	-	-	-	-	-
Executive VP and Chief Financial Officer (w)(4)	-	-	-	-	-	-	-
Acting Chief Financial Officer (x)	17	-	-	17	-	17	17
Executive VP and Chief Medical Officer, Clinical Operations (y)	-	139	(1)	138	244	382	136
Executive VP and Chief Medical Officer, Quality and Medical Affairs (z)	-	-	-	-	-	-	-
Executive VP and Chief Development Officer – SPP	19	-	-	19	-	19	7
Executive VP and Chief Development Officer – SERP (5)	-	-	(1)	(1)	301	300	96
Executive VP, People and Partners (aa)	26	-	-	26	-	26	15
Senior VP, Research (bb)	-	-	-	-	-	-	-
Senior VP, Priorities and Performance (cc)	9	-	-	9	-	9	-
Senior VP, Health Professions Strategy and Practice and Chief Nursing and Health Professions Officer – SPP (dd)	8	-	-	8	-	8	-
Senior VP, Health Professions Strategy and Practice and Chief Nursing and Health Professions Officer – SERP (dd)	-	38	1	39	159	198	48

(1) The SPP current period benefit costs are AHS contributions earned in the period.
(2) The SERP current period benefit cost is the actuarial present value of the benefits earned in the fiscal year. These are not cash payments in the period but are the cost in the period for rights to these future retirement benefits.
(3) Other SERP costs include interest expense on the obligations, offset by the expected return on the plans' assets and amortization of actuarial gains and losses.
(4) The incumbent was not entitled to earn SPP or SERP current period benefits while employed at AHS. See footnote kk.
(5) The incumbent's prior year total SERP cost has been restated to correct a calculation error.

SUB-SCHEDULE 2C - EXECUTIVE SUPPLEMENTAL PENSION PLAN AND SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN (CONTINUED)

	Account Balance or Accrued Benefit Obligation March 31, 2012	Change in actuarial assumption for discount rate	Change During the Year[1]	Account Balance or Accrued Benefit Obligation March 31, 2013
President and Chief Executive Officer from April 1, 2011 [t]	$ 44	$ -	$ 46	$ 90
President and Chief Executive Officer until April 1, 2011 [t]	1,370	406	(76)	1,700
Chief Audit Executive	11	-	6	17
Ethics and Compliance Officer	21	-	9	30
Chief of Staff and Corporate Secretary [u]	5	-	5	10
Executive VP and Chief Operating Officer	77	-	36	113
Executive VP and Chief Financial Officer [v]	-	-	-	-
Executive VP and Chief Financial Officer [w][2]	-	-	-	-
Acting Chief Financial Officer [x]	31	-	19	50
Executive VP and Chief Medical Officer, Clinical Operations [y]	763	244	88	1,095
Executive VP and Chief Medical Officer, Quality and Medical Affairs [z]	-	-	-	-
Executive VP and Chief Development Officer from December 1, 2011	7	-	19	26
Executive VP and Chief Development Officer until November 30, 2011[3]	979	301	74	1,354
Executive VP, People and Partners [aa]	15	-	27	42
Senior VP, Research [bb]	-	-	-	-
Senior VP, Priorities and Performance [cc]	-	-	9	9
Senior VP, Health Professions Strategy and Practice and Chief Nursing and Health Professions Officer from November 1, 2012 [dd]	-	-	8	8
Senior VP, Health Professions Strategy and Practice and Chief Nursing and Health Professions Officer until October 31, 2012 [dd]	317	159	91	567

(1) Changes in the accrued benefit obligation include current period benefit cost, interest accruing on the obligations, the amortization of any actuarial gains or losses in the period, and gains or losses due to curtailment.

(2) The incumbent was not entitled to earn SPP or SERP current period benefits while employed at AHS. See footnote kk.

(3) The incumbent's opening Accrued Benefit Obligation relating to SERP has been restated to correct a calculation error.

SCHEDULE 3 - CONSOLIDATED SCHEDULE OF BUDGET
YEAR ENDED MARCH 31, 2013

a) Reconciliation of the Consolidated Statement of Operations

	CGAAP Budget (Note 4)	Transition to PSAS (Note 2)	Reported Budget
Revenue:			
Alberta Health contributions/Alberta Health transfers			
Unrestricted ongoing/Base operating grant	$ 10,212,000	$ -	$ 10,212,000
Restricted/Other operating grants	1,164,000	-	1,164,000
Capital grants	-	96,000	96,000
Other government contributions/ Other government transfers	119,000	243,000	362,000
Fees and charges	439,000	-	439,000
Ancillary operations	127,000	-	127,000
Donations/Donations, fundraising and non-government grants	27,000	102,000	129,000
Investment and other income	222,000	(22,000)	200,000
Amortized external capital contributions[i]	374,000	(374,000)	-
TOTAL REVENUE	12,684,000	45,000	12,729,000
Expenses:			
Inpatient acute nursing services	2,918,000	5,000	2,923,000
Emergency and other outpatient services	1,356,000	-	1,356,000
Facility-based continuing care services	971,000	-	971,000
Ambulance services	415,000	-	415,000
Community-based care	1,054,000	-	1,054,000
Home care	496,000	-	496,000
Diagnostic and therapeutic services	2,143,000	5,000	2,148,000
Promotion, prevention and protection services	368,000	-	368,000
Research and education	234,000	15,000	249,000
Administration[ii]	397,000	39,000	436,000
Information technology	480,000	-	480,000
Support services	1,593,000	248,000	1,841,000
Amortization of facilities and Improvements[i]	259,000	(259,000)	-
TOTAL EXPENSES	12,684,000	53,000	12,737,000
OPERATING DEFICIT	$ -	$ (8,000)	$ (8,000)

When a line item has changed names it is described as "2011-12 name/2012-13 name".

[i] Line item no longer presented separately.

[ii] During 2012-13 AHS changed the definition of administration to be consistent with the Canadian Institute of Health Information definition of administration, which resulted in a budget reclassification from support services to administration.

SCHEDULE 3 - CONSOLIDATED SCHEDULE OF BUDGET
YEAR ENDED MARCH 31, 2013 (CONTINUED)

b) Reconciliation of the Consolidated Statement of Cash Flows

	CGAAP Budget (Note 4)	Transition to PSAS (Note 2)	Reported Budget
Operating transactions:			
Operating deficit	$ -	$ (8,000)	$ (8,000)
Non-cash transactions:			
Amortization, disposals and write-downs	521,000	-	521,000
Amortization of external capital contributions/ Recognition of expended deferred capital revenue	(374,000)	-	(374,000)
Bond amortization expense	-	13,000	13,000
Decrease (increase) in:			
Accounts receivable relating to operating transactions	-	(20,000)	(20,000)
Inventories for consumption	-	(8,000)	(8,000)
Other assets	-	18,000	18,000
Prepaid expenses	-	-	-
Increase (decrease) in:			
Accounts payable and accrued liabilities related to operating transactions	-	55,000	55,000
Employee future benefits	-	52,000	52,000
Deferred revenue related to operating transactions	-	(79,000)	(79,000)
Other(i)	(8,000)	8,000	-
Changes in non-cash working capital(i)	14,000	(14,000)	-
Cash provided by operating transactions	153,000	17,000	170,000
Capital transactions:			
Acquisition of tangible capital assets	(556,000)	-	(556,000)
Increase (decrease) in accounts payable and accrued liabilities related to capital transactions	-	13,000	13,000
Changes in non-cash working capital(i)	13,000	(13,000)	-
Cash applied to capital transactions	(543,000)	-	(543,000)
Investing transactions:			
Purchase of portfolio investments	(4,310,000)	-	(4,310,000)
Proceeds on sale of portfolio investments	4,535,000	(13,000)	4,522,000
Allocation from (to) non-current cash and investments(i)	(269,000)	269,000	-
Cash provided by (applied to) investing transactions	(44,000)	256,000	212,000
Financing transactions:			
Capital contributions received/ Deferred capital revenue received	163,000	-	163,000
Capital contributions returned/ Deferred capital revenue returned	(107,000)	-	(107,000)
Capital contributions payable transferred from accounts payable/ Deferred capital revenue payable transferred from accounts payable and accrued liabilities	107,000	-	107,000
Proceeds from debt	32,000	-	32,000
Principal payments on debt	(38,000)	-	(38,000)
Cash provided by financing transactions	157,000	-	157,000
Net increase (decrease) in cash and cash equivalents	(277,000)	273,000	(4,000)
Cash and cash equivalents, beginning of year	1,789,000	(952,000)	837,000
Cash and cash equivalents, end of year	$ 1,512,000	$ (679,000)	$ 833,000

When a line item has changed names it is described as "2011-12 name/2012-13 name".
(i)Line item no longer presented separately.

SCHEDULE 3 - CONSOLIDATED SCHEDULE OF BUDGET
YEAR ENDED MARCH 31, 2013 (CONTINUED)

c) Reconciliation of the Consolidated Schedule of Expenses by Object

	CGAAP Budget (Note 4)	Transition to PSAS (Note 2)	Reported Budget
Salaries and benefits	$ 6,838,000	$ 13,000	$ 6,851,000
Contracts with health service providers	2,265,000	-	2,265,000
Contracts under the Heath Care Protection Act	21,000	-	21,000
Drugs and gases	386,000	-	386,000
Medical and surgical supplies	354,000	-	354,000
Other contracted services	1,148,000	-	1,148,000
Other	1,151,000	40,000	1,191,000
Amortization, disposals and write-downs	521,000	-	521,000
	$ 12,684,000	$ 53,000	$ 12,737,000

SCHEDULE 4 – TRANSITION TO PUBLIC SECTOR ACCOUNTING STANDARDS

a) Reconciliation of the Consolidated Statement of Operations

	March 31, 2012 CGAAP	Transition to PSAS (Note 2)	Other Reclassifications[ii]	March 31, 2012 PSAS
Revenue:				
Alberta Health contributions/Alberta Health transfers				
Unrestricted ongoing/Base operating grant	$ 9,634,221	$ -	$ -	$ 9,634,221
Restricted/Other operating grants	835,412	-	-	835,412
Capital grants	-	120,522	-	120,522
Other government contributions/ Other government transfers	141,391	201,965	2,405	345,761
Fees and charges	416,385	-	-	416,385
Ancillary operations	124,213	-	(2,650)	121,563
Donations/Donations, fundraising and non-government grants	39,535	70,641	36,328	146,504
Investment and other income	248,299	1,475	(36,083)	213,691
Amortized external capital contributions[i]	342,305	(342,305)	-	-
TOTAL REVENUE	11,781,761	52,298	-	11,834,059
Expenses:				
Inpatient acute nursing services	2,812,157	928	(52,339)	2,760,746
Emergency and other outpatient services	1,279,016	-	35,328	1,314,344
Facility-based continuing care services	893,482	-	(26,895)	866,587
Ambulance services	391,674	-	2,911	394,585
Community-based care	920,594	-	(6,846)	913,748
Home care	428,814	-	24,009	452,823
Diagnostic and therapeutic services	1,930,120	63	31,066	1,961,249
Promotion, prevention and protection services	310,914	-	49	310,963
Research and education	198,035	19,539	429	218,003
Administration	363,921	49,531	(16,174)	397,278
Information technology	434,442	-	897	435,339
Support services	1,528,142	185,788	7,565	1,721,495
Amortization of facilities and improvements[i]	205,859	(205,859)	-	-
TOTAL EXPENSES	11,697,170	49,990	-	11,747,160
OPERATING SURPLUS	$ 84,591	$ 2,308	$ -	$ 86,899

When a line item has changed names it is described as "2011-12 name/2012-13 name".

[i] Line item no longer presented separately.

[ii] Other reclassifications include amounts reclassified to conform to the 2013 presentation.

SCHEDULE 4 – TRANSITION TO PUBLIC SECTOR ACCOUNTING STANDARDS (CONTINUED)

b) Reconciliation of opening Consolidated Statement of Financial Position

	April 1, 2011 CGAAP	Transition to PSAS (Note 2)	Other Reclassifications(iii)	April 1, 2011 PSAS
Assets:				
Cash and cash equivalents	$ 764,143	$ 359,969	$ -	$ 1,124,112
Non-current cash and investments(i)	599,335	(599,335)	-	-
Investments/Portfolio investments	957,322	448,724	-	1,406,046
Accounts receivable	201,293	5,373	288,726	495,392
Contributions receivable from AH(i)	200,313	11,476	(211,789)	-
Capital contributions receivable from AH(i)	11,476	(11,476)	-	-
Other assets	96,104	(2,720)	(76,937)	16,447
Capital assets/Tangible capital assets	6,707,464	-	-	6,707,464
Inventories/Inventories for consumption	99,097	-	-	99,097
Prepaid expenses	58,946	1,034	-	59,980
TOTAL ASSETS	$ 9,695,493	$ 213,045	$ -	$ 9,908,538
Liabilities:				
Accounts payable and accrued liabilities	$ 1,136,937	$ (383,363)	$ 530,858	$ 1,284,432
Employee future benefits	-	470,966	-	470,966
Accrued vacation pay(i)	385,525	171	(385,696)	-
Deferred revenue	-	110,312	6,758,600	6,868,912
Long-term debt/Debt	182,500	153,799	-	336,299
Current portion of long-term debt(i)	153,799	(153,799)	-	-
Deferred contributions current(i)	607,621	-	(607,621)	-
Deferred capital contributions(i)	541,856	-	(541,856)	-
Unamortized external capital contributions(i)	5,598,973	-	(5,598,973)	-
Other liabilities(i)	144,540	622	(145,162)	-
TOTAL LIABILITIES	8,751,751	198,708	10,150	8,960,609
Net assets:				
Accumulated surplus/Accumulated operating surplus(ii)	98,909	785,915	-	884,824
Other internally restricted net assets/Reserves for future purposes	66,722	(66,722)	-	-
Internally restricted net assets invested in capital assets/Net assets invested in tangible capital assets	777,071	(777,071)	-	-
Accumulated net unrealized gains (losses) on investments/Accumulated unrealized net gains	(9,110)	12,442	-	3,332
Endowments	10,150	59,773	(10,150)	59,773
TOTAL NET ASSETS	943,742	14,337	(10,150)	947,929
	$ 9,695,493	$ 213,045	$ -	$ 9,908,538

When a line item has changed names it is described as "2011-12 name/2012-13 name".

(i) Line item no longer presented separately.

(ii) Definition changed under PSAS to also include reserves for future purposes and net assets invested in tangible capital assets.

(iii) Other reclassifications include amounts reclassified to conform to the 2013 presentation.

SCHEDULE 4 – TRANSITION TO PUBLIC SECTOR ACCOUNTING STANDARDS (CONTINUED)

c) Reconciliation of the Consolidated Statement of Financial Position

	March 31, 2012 CGAAP	Transition to PSAS (Note 2)	Other Reclassifications(iii)	March 31, 2012 PSAS
Assets:				
Cash and cash equivalents	$ 558,700	$ 253,826	$ -	$ 812,526
Non-current cash and investments(i)	376,505	(376,505)	-	-
Investments/Portfolio investments	1,217,043	339,203	-	1,556,246
Accounts receivable	238,757	2,022	172,721	413,500
Contributions receivable from AH(i)	78,253	2,293	(80,546)	-
Capital contributions receivable from AH(i)	2,293	(2,293)	-	-
Other assets	129,493	764	(92,175)	38,082
Capital assets/Tangible capital assets	7,215,171	-	-	7,215,171
Inventories/Inventories for consumption	96,740	-	-	96,740
Prepaid expenses	59,100	486	-	59,586
TOTAL ASSETS	$ 9,972,055	$ 219,796	$ -	$ 10,191,851
Liabilities:				
Accounts payable and accrued liabilities	$ 1,198,261	$ (426,252)	$ 576,574	$ 1,348,583
Employee future benefits	-	514,515	-	514,515
Accrued vacation pay(i)	428,146	186	(428,332)	-
Deferred revenue	-	109,917	6,795,142	6,905,059
Long-term debt/Debt	331,177	38,802	-	369,979
Current portion of long-term debt(i)	38,802	(38,802)	-	-
Deferred contributions current(i)	450,360	-	(450,360)	-
Deferred capital contributions(i)	359,918	-	(359,918)	-
Unamortized external capital contributions(i)	5,974,714	-	(5,974,714)	-
Other liabilities(i)	147,719	523	(148,242)	-
TOTAL LIABILITIES	8,929,097	198,889	10,150	9,138,136
Net assets:				
Accumulated surplus/Accumulated operating surplus(ii)	81,982	889,741	-	971,723
Other internally restricted net assets/Reserves for future purposes	69,538	(69,538)	-	-
Internally restricted net assets invested in capital assets/Net assets invested in tangible capital assets	876,372	(876,372)	-	-
Accumulated net unrealized gains (losses) on investments/Accumulated unrealized net gains	4,916	13,336	-	18,252
Endowments	10,150	63,740	(10,150)	63,740
TOTAL NET ASSETS	1,042,958	20,907	(10,150)	1,053,715
	$ 9,972,055	$ 219,796	$ -	$ 10,191,851

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(i) Line item no longer presented separately.

(ii) Definition changed under PSAS to also include reserves for future purposes and net assets invested in tangible capital assets.

(iii) Other reclassifications include amounts reclassified to conform to the 2013 presentation.

SCHEDULE 4 – TRANSITION TO PUBLIC SECTOR ACCOUNTING STANDARDS (CONTINUED)

d) Reconciliation of the Consolidated Statement of Cash Flows

	March 31, 2012 CGAAP	Transition to PSAS (Note 2)	Other Reclassifications[ii]	March 31,2012 PSAS
Operating transactions:				
Operating surplus	$ 84,591	$ 2,308	$ -	$ 86,899
Non-cash transactions:				
Amortization, disposals and write-downs	474,513	(70)	94	474,537
Amortization of external capital contributions/ Recognition of expended deferred capital revenue	(342,550)	-	-	(342,550)
Revenue recognized for acquisition of land	-	(599)	-	(599)
Bond amortization expense	-	22,781	-	22,781
Decrease (increase) in:				
Accounts receivable relating to operating transactions	-	87,947	-	87,947
Inventories for consumption	-	2,357	-	2,357
Other assets	-	(21,541)	(94)	(21,635)
Prepaid expenses	-	394	-	394
Increase (decrease) in:				
Accounts payable and accrued liabilities related to operating transactions	-	45,283	-	45,283
Employee future benefits	-	43,549	-	43,549
Deferred revenue related to operating transactions	-	(161,110)	-	(161,110)
Other[i]	(14,947)	14,947	-	-
Changes in non-cash working capital[i]	(245,106)	245,106	-	-
Cash provided by (applied to) operating transactions	(43,499)	281,352	-	237,853
Capital transactions:				
Acquisition of tangible capital assets	(486,916)	-	-	(486,916)
Increase (decrease) in accounts payable and accrued liabilities related to capital transactions	-	18,868	-	18,868
Changes in non-cash working capital[i]	18,868	(18,868)	-	-
Cash applied to capital transactions	(468,048)	-	-	(468,048)
Investing transactions:				
Purchase of portfolio investments	(5,099,643)	2,153,236	-	(2,946,407)
Proceeds on sale of portfolio investments	5,297,831	(2,509,485)	-	2,788,346
Allocation from (to) non-current cash and investments	38,668	(38,668)	-	-
Cash provided by (applied to) investing transactions	236,856	(394,917)	-	(158,061)
Financing transactions:				
Capital contributions received/Deferred capital revenue received	171,081	7,422	-	178,503
Capital contributions returned/Deferred capital revenue returned	(15,759)	-	-	(15,759)
Capital contributions payable transferred to accounts payable/Deferred capital revenue payable transferred to accounts payable and accrued liabilities	(119,754)	-	-	(119,754)
Proceeds from debt	194,000	-	-	194,000
Principle payments on debt	(160,320)	-	-	(160,320)
Cash provided by financing transactions	69,248	7,422	-	76,670
Net decrease in cash and cash equivalents	(205,443)	(106,143)	-	(311,586)
Cash and cash equivalents, beginning of year	764,143	359,969	-	1,124,112
Cash and cash equivalents, end of year	$ 558,700	$ 253,826	$ -	$ 812,526

[i] Line item no longer presented separately. When a line item has changed names it is described as "2011-12 name/2012-13 name".
[ii] Other reclassifications include amounts reclassified to conform to the 2013 presentation.

SCHEDULE 4 – TRANSITION TO PUBLIC SECTOR ACCOUNTING STANDARDS (CONTINUED)

e) Reconciliation of the Consolidated Schedule of Expenses by Object

	March 31, 2012 CGAAP	Transition to PSAS (Note 2)	Other Reclassifications[i]	March 31, 2012 PSAS
Salaries and benefits	$ 6,156,248	$ 4,777	$ -	$ 6,161,025
Contracts with health service providers	2,040,509	-	(22,249)	2,018,260
Contracts under the Heath Care Protection Act	18,434	-	-	18,434
Drugs and gases	387,984	-	-	387,984
Medical and surgical supplies	360,002	-	-	360,002
Other contracted services	1,038,221	(4,538)	22,249	1,055,932
Other	1,221,259	49,751	(24)	1,270,986
Amortization, disposals and write-downs	474,513	-	24	474,537
	$ 11,697,170	$ 49,990	$ -	$ 11,747,160

[i] Other reclassifications include amounts reclassified to conform to the 2013 presentation.

Appendix

2012-13 Performance Results

Health Quality Council of Alberta

Surgical Contracts

List of AHS Funded Facilities

Bed Numbers by Zone

Partner Foundations and Health Trusts

2012-13 Performance Results

As required by Alberta Health, detailed information describing measures, targets and results/progress relative to the expectations set out in the AHS Health Plan and Business Plan, are provided in the following pages.

Of the measures we are tracking, the majority of them indicate continual improvement. Some of these improvements are small, while others show quite significant changes in the right direction. Some areas require additional effort to move the results closer to our goals. We are bolstered by the progress and we also recognize there is a great deal of work ahead. We've come a long way since the former health regions were amalgamated into Alberta Health Services, but we are not there yet. We will keep working to improve and we will continue to update you on our progress.

In collaboration with AH, AHS established performance goals and a road map of improvements to help us continue to build and strengthen this high-performing system. These targets were deliberately set to be very ambitious and challenging to achieve, to provide a focus for improvement, and to mobilize action. To move us forward, AHS and Alberta Health developed the *Alberta's Health System Outcomes and Measurement Framework.*

Over the course of the past year, we have undertaken many activities which are helping us advance our goals. We also monitor our progress every step of the way. The section that follows identifies some of the key initiatives that are underway, along with performance metrics.

1. Assess on an ongoing basis the health needs of Albertans

In order to realize a future with a high-performing health system and a population with high uptake on wellness initiatives and self care, the health system requires significant innovations in the areas of health and well-being, primary care integration, specialized and continuing care transitions, health system management enablers and workforce optimization. In order to be successful, initial steps toward required longer term changes and a sustainable future must occur over the next few years.

PRIORITIES FOR ACTION: **HEALTH NEEDS**
Understand the health needs of Albertans in the short and long term. Provide Albertans with health indicator information.

ACTIONS	PROGRESS/RESULTS
Continue to work with Alberta Health and others to ensure appropriate health status information is available by community, local area, and zone and provincially.	• AHS produces the following health status information by community, local area, and zone and provincial levels: estimated prevalence rates for all chronic conditions and complex high needs populations, health status levels based on clinical risks groupings, and life expectancy. • AHS continues to work with AH to report on Healthy Lifestyle and Risk Behaviour health status measures (smoking, healthy weights, etc.) at more detailed geographic levels using national survey work.
Work with communities throughout the province to assess health and service needs, and to develop plans for service delivery that respond to local needs while leveraging the advantages of the broader provincial standards and services.	• The goal of the Community Assessment and Service Response (CASR) process is to apply a standardized and collaborative approach to health service planning and consultation across rural Alberta. This work is aligned with and informs zone health service planning. • The CASR helps identify the health needs of communities and matches those needs with currently available services. Gaps in services are identified and action plans are developed to address key gaps in services. These action plans are both developed and implemented by those living and/or working in these communities to ensure they adequately address the unique context of each particular community. • The CASR process began in two communities – High River and Cardston-Kanai. Service plans are completed for Banff/Canmore and in process for Oyen, Slave Lake, Stony Plain, Vegreville/Two Hills. Engagement sessions were held with the public, staff and physicians in each of these communities and engagement reports have been developed. Health Needs Assessments have been completed for service optimization in eight other communities across the province.
Work continues to assess and plan for the changing demand for health services across Alberta over the next 20 years.	• The zone-based 2030 Sustainability and Service Plan (2030 Plan) is a translational plan that cascades from provincial strategy and standards to create a cohesive and sustainable geographic response to local needs and priorities. The 2030 Plan will inform and influence provincial portfolio and Strategic Clinical Network (SCN) future direction and priorities. • 2030 Plans will help establish geographical priorities, major service changes (service type, location and capacity) and supporting space needs and related capital projects over the short, medium and long term. • The 2030 Sustainability and Service Planning Framework has been drafted outlining consistent processes, planning principles, access guidelines and service planning approaches used by each zone. 2030 planning is currently underway in Edmonton.
Develop processes and infrastructure to support assessment, service planning and performance reporting.	
Continue the development of data repositories, data quality improvement, data analysis, and knowledge management and transfer activities to support provincial and local service planning and performance reporting.	• The AHS Data Repository for Reporting now houses over 20 provincial datasets. This corporate data asset is leveraged by more than 100 analysts for a wide range of analytical and reporting purposes. • New web-based performance reporting software has been deployed, delivering critical performance information to decision-makers. Over 50 dashboards are now available to SCNs, zones and other clinical or administrative teams to inform service planning and quality improvement opportunities. • Health Technology Assessment and Innovation as well as Knowledge Management are developing and advancing tools and mechanisms to support the SCNs in bringing validated evidence to inform practice and decisions.

In Summary: In conjunction with Alberta Health, we are building foundational elements required for a more robust approach of assessment, performance reporting and allocating resources to allow AHS to move forward in the next fiscal year.

2. Determine Priorities in the Provision of Health Services in Alberta and Allocate Resources

AHS has identified key drivers that will help improve the health of Albertans and advance our goals of improving access, quality and sustainability. While there will always be more demand for service than the organization can reasonably fulfill, it is essential that the organization respond in an integrated manner, establish key priorities and invest its resources for the greatest impact in both the short and long term.

PRIORITIES FOR ACTION: HEALTH SERVICE PRIORITIES AND RESOURCE ALLOCATION

ACTIONS (in collaboration with AH)	PROGRESS/RESULTS
Foundational work allocating cost to patient level.	• In collaboration with AH, planning and evaluation tools are being designed to enable AHS to demonstrate value-for-money for its new initiatives, in keeping with Results-Based Budgeting (RBB) principles. A framework was created demonstrating how consistent language and analytical tools can be deployed to facilitate decision-making and assess and evaluate projects in the approval process, in-flight and post-implementation. This will be used across AHS to enable early assessment and post evaluations of initiatives for both cost and value for patients.
AHS ability to identify complex high needs population.	• A significant insight that emerged from work on the Ministerial directives related to the Health Quality Council of Alberta (HQCA) report on emergency department use was the need to better manage demand on our emergency and acute care system. Currently, 5% of the population of Alberta is utilizing services that account for 60% of costs associated with inpatient, emergency and urgent care, and general practitioner and specialty physician services. • AHS is closely examining how we can deliver more appropriate care to these complex high needs populations. A care approach was developed for two urban pilot projects based on an "Integrated Health Home" model within the existing Family Care Clinics (FCC) in East Edmonton and East Calgary. AHS is addressing the need for system redesign by leveraging the full potential of FCCs and community resources to improve integration of local service delivery within a broader health system. Subsequent phases will focus on developing predictive approaches and early intervention models that would help reduce or delay progression to these complex high needs states.

In Summary: AHS worked very closely with Alberta Health to develop a document that sets the direction for Alberta's health system to meet today's challenges and achieve a sustainable health system.

Recognizing that there are multiple requests for investment to be balanced against finite resources, it is important to review and prioritize each initiative. The AHS Initiative Priority Setting Tool assists in assessing the benefits / contributions and risks of each initiative relative to their cost.

3. Ensure that reasonable access to quality health services is provided in and throughout Alberta Health Services

Improve Access and Reduce Wait Times

Timely and appropriate access supports good clinical outcomes. Deterioration of health is reduced, unnecessary duplication of investigations is avoided and the burden to individuals, families and supports is minimized as much as possible.

Over the last 10 to 15 years access to services has become increasingly difficult due to a number of factors, including population growth, an aging population, disease complexity, system expansion and reorganization, public expectation, and workforce changes. Alberta Health Services recognizes the need to address each of those components in order to achieve optimal outcomes for Albertans.

PRIORITIES FOR ACTION: **ACCESS TO SURGERY**
Reduce the wait time for surgical procedures.

ACTIONS	PROGRESS/RESULTS
Continue to increase surgical capacity through increased volumes, implementation of wait time management systems, and more efficient use of operating rooms. Provincial Access Team/ Wait Time Measurement and Management Program: Implement Adult Canadian Access Targets for Surgery (ACATs) as standard provincial waitlist tool across targeted surgical specialties. Implement wait list policy and cleanup for targeted surgical clinics.	• The aCATS project is to develop and implement a standardized diagnosis-based priority system to book surgeries throughout the province. The system measures, monitors, and manages access to surgical services at each hospital site, and supports comparisons throughout the province. The pilot project has a number of benefits including: • Provincially standardized access targets across surgical services, thereby improving comparability of wait time data and ability to benchmark. • Standardized real time measuring, monitoring and managing of surgical wait lists. • Ensure only appropriate candidates for surgery will be placed on surgical wait lists. • Develop recommendations for increasing capacity within existing resources, and identify areas requiring additional resources to meet demand and access targets. • Manage surgical access across the province; ensuring patients receive their surgery within the access targets. • All surgical subspecialties from across Alberta are developing access targets related to diagnosis and urgency. • aCATS is now live at all nine pilot sites which includes University of Alberta Hospital, Royal Alexandra Hospital, Grey Nuns Hospital, Fort Saskatchewan Health Centre, Foothills Medical Centre, Peter Lougheed Centre, Rockyview General Hospital, Stollery Children's Hospital and Alberta Children's Hospital. • Eleven of 13 specialties are using the aCATS codes with target wait times attached. Exception being Cardiac Surgery and Podiatry. • Wait list cleanup at surgeon's offices for pilot sites is complete and standards for ongoing wait list clean up established.
Review central intake methodologies to improve "next available surgeon" options to new referrals.	• The Bone and Joint Strategic Clinical Network in partnership with the Alberta Bone and Joint Health Institute is leading the development of an applied research program that will serve to inform the development of centralized referrals as a triaging strategy for musculoskeletal in Alberta.
Cardiac - Implement cardiac surgery/ coronary artery bypass graft (CABG) wait time improvement project.	• In Calgary, several improvement projects were implemented including scheduling systems and optimizing the use of operating room utilization. A registered nurse navigator is working with surgeons to identify when to schedule patients for surgery and to monitor volume and duration of all-day cases for optimized scheduling. • In Edmonton, ongoing quality improvement work is occurring in the areas of patient flow, patient education, operating room utilization and surgical site infection, as well as improvement of the surgical wait time database. • Together, Calgary and Edmonton Zones are working collaboratively on surgical wait times, in conjunction with surgeon's offices to identify strategies for continuous improvement.
Hip and Knee - Implement year 2 hip and knee arthroplasty volumes across zones.	• More surgeries have been performed year-to-date this year than over the past two fiscal years with an almost 16% increase in surgical volume for hip, and 21% increase for knees. One example to reduce hip replacement is the Fragility and Stability Program which identifies and delivers prevention and promotion strategies for Albertans experiencing or at risk of experiencing osteoporosis-related fractures. The program also improves supports to those experiencing hip fracture, with the goal of shortening the amount of time these patients spend in acute care settings and returning patients to independent living.

PRIORITIES FOR ACTION: ACCESS TO SURGERY
Reduce the wait time for surgical procedures.

ACTIONS	PROGRESS/RESULTS
Cataract - Implement Year 2 cataract volumes across zones.	• Compared to last year this time, there has been significant improvement in wait times as we move closer to target. A pilot project to implement a standardized diagnosis-based priority system to book surgeries throughout the province was sponsored by the Surgery Clinical Network. The goal of this project was to implement Adult Coding Access Targets for Surgery (aCATS) and Pediatric Canadian Access Targets for Surgery (pCATS).
Lung surgery - Implement 184 additional lung surgeries by March 31, 2013.	• The Calgary Zone launched a pilot program in November 2012 with expansion to the Edmonton Zone, to increase the number of new referrals into the clinics through the implementation and communication of standard referral criteria to primary care providers and select radiologists. Initial results have demonstrated success in this program.

In Summary: AHS continues to increase the number of surgeries performed. More joint replacement surgeries have been performed year-to-date this year since 2010/11. Zones continue to collaborate with the Alberta Bone and Joint Institute to address wait times, and continue to work with home care to ensure appropriate home care referrals in order to get patients home sooner. Central Zone continues to work with Prairie North Health Region in Saskatchewan (Lloydminster Hospital) on the potential to enhance orthopaedic programming. North Zone continues to collaborate with Edmonton Zone to address patient wait times. A pilot project to implement a standardized diagnosis-based priority system to book surgeries throughout the province was sponsored by the Surgery Clinical Network. The goal of this project was to implement Adult Coding Access Targets for Surgery (aCATS) and Pediatric Canadian Access Targets for Surgery (pCATS).

The most dramatic improvement was seen in cataract surgery where wait times are 29.0 weeks in 2012-13, down from 37.3 weeks last year, a 22 per cent improvement. A number of initiatives reduced wait times for hip, knee, cataracts and other surgeries in 2012-13, and we anticipate continued improvement in the upcoming year as wait lists are reduced.

Province-Wide Access to Surgery: Wait Times as defined by the maximum time that nine out of ten people will wait (in weeks) from decision to treat to treatment.

WAIT TIMES FOR SURGERY	2009 / 2010	2010 / 2011	2011 / 2012	2012 / 2013	2012 / 2013 TARGETS
Province-Wide Access to Surgery: Wait Times as defined by the maximum time that nine out of ten people will wait (in weeks) from decision to treat to treatment.					
CABG Urgency I - Urgent	2.4 weeks	2.1 weeks	1.9 weeks	2.0 weeks	1.0 week
CABG Urgency II – Semi Urgent	7.0 weeks	6.4 weeks	6.2 weeks	4.7 weeks	2.0 weeks
CABG Urgency III - Scheduled	31.0 weeks	24.0 weeks	28.8 weeks	25.9 weeks	6.0 weeks
Wait Time for Hip Replacement Surgery:	36.4 weeks	38.9 weeks	39.8 weeks	36.3 weeks	22.0 weeks
Wait Time for Knee Replacement Surgery:	49.1 weeks	48.9 weeks	48.0 weeks	40.9 weeks	28.0 weeks
Wait Time for Cataract Surgery:	41.0 weeks	46.9 weeks	37.3 weeks	29.0 weeks	25.0 weeks
Wait Time for all other Scheduled Surgery	24.6 weeks	25.7 weeks	25.9 weeks	26.1 weeks	n/a

CABG = Coronary Artery Bypass Graft.

Sources: AHS Open Heart Waitlist Database (Edmonton), VELOS, APPROACH and OR data from ORIS, the OR database (Calgary); DIMR from Site Surgery Wait List and Surgical Databases; and Alberta Health

PRIORITIES FOR ACTION: **CANCER CARE**

Increase access for the treatment of cancer.

ACTIONS	PROGRESS/RESULTS
Use LEAN process to assess patient and paper workflow from receipt of referral to consult.	• A LEAN project was initiated to address increased wait time at three centres: the Cross Cancer Institute in Edmonton, the Tom Baker Centre in Calgary, and the Jack Ady Centre in Lethbridge.
Standardize referral guidelines: standardize referring information by tumour group.	• Standardizing the referral process across all zones and testing of new e-referral technology is being rolled out across the remaining tumour groups and are anticipated to be completed by the end of 2013. Completion of this work will result in better access to cancer treatment for Albertans.
Expand initial first patient contact pilot project to all tumour groups to decrease triage time and overall wait times. Evaluate current roles and scope, new roles and expansion of current roles to full scope of practice to maximize effectiveness of current staffing.	• Clinicians in various tumour groups developed and implemented standardized provincial referral and triage guidelines for patients with a cancer confirmed diagnosis. • Community oncology was implemented at Jack Ady Cancer Centre, Margery E Yuill Cancer Centre, Grande Prairie Cancer Centre, and Central Alberta Cancer Centre. All sites achieving over 90% of patients contacted within 48 hours. Community Oncology is focusing on strategies to improve rates of patients contacted within 48 hours with a confirmed appointment. • At the Tom Baker Cancer Centre, more than 90% of patients within all tumour groups are now contacted within 48 hours of their referral. • The initiatives are projected to lead to increased clinic rooms, radiation therapy treatments, daycare slots, etc.
Radiation therapy wait time: implement referral to first consult improvement project.	• Improvement processes are underway to address the increased wait times at three centres within Alberta focusing on reducing the time required to receive, process, and triage patient referrals, as well as review of scheduling and resource utilization.
Develop the Cancer Care Strategic Clinical Network.	• The Cancer Care Strategic Clinical Network is one of six SCNs established in 2012-13. One of its key objectives is to improve access to high quality care for Albertans through transformation of the traditional referral processes and improve navigation and access to cancer services.
Implement a provincial cancer patient navigation strategy aligned with the system-wide navigation and case management initiative.	• Patient Navigators are in place at 10 out of the 11 Community Cancer Centres at all four associate cancer centres. Navigators answer questions, address concerns and provide support and resources at a time when cancer patients can feel overwhelmed by the complexity of the medical system and the reality of their diagnosis. They also work to ensure patients and their families get access to needed services and supports, regardless of where they live or where they are on their cancer journey.

In Summary: Improvements have been made to reduce wait times for radiation therapy both in "referral to first consult" and in "ready to treat to first radiation treatment" categories. There has been significant improvement in the past two years, with "ready to treat to first radiation treatment" continuing to be better than target. While improvements have been made reducing wait times for "referral to first consult", targets have not yet been achieved.

PERFORMANCE MEASURE	2009 / 2010	2010 / 2011	2011 / 2012	2012 / 2013	2012 / 2013 TARGETS
Wait time for radiation therapy - *referral to first consult*: From referral to the time of their first appointment with a radiation oncologist:					
Cross Cancer Institute	7.7 weeks	6.0 weeks	4.9 weeks	4.9 weeks	3 weeks
Jack Ady Cancer Centre	n/a	4.5 weeks	3.7 weeks	3.9 weeks	
Tom Baker Cancer Centre	5.4 weeks	6.0 weeks	6.3 weeks	4.9 weeks	
Provincial	**7.4 weeks**	**6.0 weeks**	**5.3 weeks**	**4.8 weeks**	
Wait time for radiation therapy - *Ready to Treat to First Radiation Treatment:* From the time of a medical prescription for radiation therapy to the start of radiation therapy:					
Cross Cancer Institute	6.0 weeks	3.4 weeks	3.0 weeks	3.0 weeks	4 weeks
Jack Ady Cancer Centre	n/a	2.1 weeks	1.4 weeks	1.0 week	
Tom Baker Cancer Centre	4.4 weeks	3.7 weeks	3.4 weeks	3.1 weeks	
Provincial	**5.4 weeks**	**3.6 weeks**	**3.1 weeks**	**3.0 weeks**	

Source: Cancer Care

PRIORITIES FOR ACTION: EMERGENCY DEPARTMENT SERVICES

Reduce long-stay patients in hospitals to free capacity for acute-care patients by ongoing initiatives.

ACTIONS	PROGRESS/RESULTS
Continue to reduce long-stay patients in hospitals to free capacity for acute-care patients by ongoing initiatives.	Path to Home (P2H) is a standard model for discharge planning to enhance how acute care capacity is managed and improve patient experience. This work will impact flow from the Emergency Department to community care and improve the way the public experiences their care throughout this journey. AHS is moving to a standard provincial approach. This work is designed to complement existing work happening in the zones and we anticipate that zones will be able to innovate on this model and adapt it to local needs. Path to Home is working to: • Reduce patient length of stay in acute care. • Align with supporting initiatives such as Workforce Model Transformation and Destination Home. • Provide a platform for the implementation of Strategic Care Network (SCN) care pathways.
Further enhance EMS practitioner role by expanding assess/ treat/ refer protocols to avoid unnecessary transports to emergency departments through expansion of Community Health and Pre-Hospital Support Program (CHAPS).	• The provincial Health Integration Program involves ongoing work managing existing situations where EMS practitioners are assisting in facilities. There is consideration for expansion to other communities, as there has been considerable interest expressed across the province for this program. Paramedics assist in hospitals doing basic routine skills (such as ECG's, IV's, some lifting or patient assessments) however they do not assume a patient load. Planning underway for a more formal approach to the implementation and management of these initiatives will help identify roles, accountabilities and resource allocations. • The Community Health and Pre-Hospital Support (CHAPS) program is available province-wide. The CHAPs referral process became electronic for AHS EMS providers and has resulted in increased referrals. CHAPS utilizes EMS practitioners to identify individuals living in the community who may need home care or other services to lower their risk of falls and/or deteriorating health. An assessment tool is used to assist in identifying at-risk individuals.
Expand primary health care options for services throughout the province, in order to improve 24/7 access to services.	• Three pilot Family Care Clinic (FCC) sites in Edmonton, Calgary and Slave Lake have been open for almost one year. The three pilot site FCCs continue to provide better access to populations identified as having higher needs for primary health care as well as issues with access. Work is underway to develop reporting metrics so that the full impact and outcomes of FCCs in their communities can be better understood.
Continue collaboration with Alberta Health on primary health care improvements.	• Linkages and working groups have been established to support the ongoing development of collaborative practice in AHS primary care, including Primary Care Networks (PCNs). Work also continues with Alberta Health to support collaborative practice development for the launch of the first wave of FCCs. • Access Improvement Measures (AIM) is underway in many aspects of primary care including Addiction and Mental Health and Public Health Immunization. Alberta AIM is a made-in-Alberta initiative to improve quality by supporting health care teams to become more efficient and reduce wait times.
Ensure the best use of hospital beds through new services, better hospital flow, and better integration with community and tertiary care teams.	• The new Path to Home process is expected to reduce average lengths of stay for patients, which will help address hospital occupancy rates. The model has evolved to encompass standards and processes for the management of acute site capacity. • Implementation of the anticipated day of discharge, patient whiteboards, Path to Home Journals and improved Medworxx utilization is underway in each of the five zones. • Emergency Medical Services is preparing for a provincial implementation of their "on time pickup" service level agreement. • The Medworxx System rollout is complete in all urban and regional facilities with the exception of Grande Prairie scheduled go live in early summer 2013. • REPAC, or Real-Time Emergency Department Patient Access & Coordination, is a system that uses real-time information from the Emergency Department (ED) to display patient volumes, incoming EMS volumes and the severity of patient conditions in Calgary/Edmonton hospitals and urgent care centers provides a window into ED workload, assists with managing existing capacity and allows EMS to get back on the street faster. • Emergency department wait times in Edmonton were made available to the public in May 2012. (Calgary went live in 2011). Monitors to display wait times in Calgary and Edmonton ED waiting rooms have been installed.

In Summary: AHS emergency departments report continuing improvement in the number of patients admitted and discharged within eight and four hours, respectively. Despite the positive trend, AHS did not meet its targets within the 2012-13 fiscal year. A series of system-wide initiatives have been implemented to continually improve Albertans' access to emergency care. These include adding new hospital beds, utilizing capacity protocols that quickly improve patient flow during periods of high demand, and continuing to implement Path to Home, a standardized model for proactive discharge to enhance how home acute care capacity.

The chart below demonstrates improvements from previous years at the same time the volume of activity seen in the Emergency Department grew 4 per cent from 2,029,225 to 2,116,474; and Urgent Care visits increased 4 per cent from 196,268 to 204,446. While achievement of targets did not occur, it is well recognized that the length of stay in Emergency Departments is dependent on the functioning of the entire system. In addition it should be noted that the volume of activity in the busiest 16 sites increased by almost 7 per cent.

PERFORMANCE MEASURE	2009 / 2010	2010 / 2011	2011 / 2012	2012 / 2013	2012 / 2013 TARGETS
Percentage of patients treated and discharged from the Emergency Department within 4 hours					
Busiest 16 sites	63%	64%	65%	65%	80%
All sites	80%	80%	80%	80%	86%
Percentage of patients treated and admitted to hospital from the Emergency Department within 8 hours					
Busiest 15 sites	38%	41%	45%	45%	75%
All sites	49%	53%	55%	55%	75%

Sources: Calgary and Edmonton Emergency Department Information System Data (REDIS, EDIS) and AHS Ambulatory Care Reporting System Data (ACRS, NACRS)

PRIORITIES FOR ACTION:
Help Albertans find their way around the health system.

ACTIONS	PROGRESS/RESULTS

Implement strategies to further support people to navigate through the system.	• Initial work has begun on identifying the health of Alberta's current complex high needs populations while improving their experience of care.
	• Health Link Alberta provides health advice and information through a toll-free phone number to all Albertans. Access is 24 hours, 7 days a week and support is provided by experienced registered nurses and other health care professionals. Enhanced and expanded service options include:
	  • Alberta Referral Directory was launched and provides access to information on specialist referral requirements.
	  • Planning finalized for implementation of Obesity Pediatric Central Access.
	  • Tweets on common health concerns and emerging health topics provided weekly to AHS Social Media team.
	• MyHealth.Alberta.ca is a Government of Alberta initiative in partnership with AHS. The information and tools found on MyHealth.Alberta.ca were developed in consultation with health professionals. MyHealth.Alberta.ca is growing by adding new content and functions that will help more Albertans to manage their own health. New additions include a new site design, more health videos and new health topic content such as information about influenza and bed bugs.

PERFORMANCE MEASURE	2008 / 2009	2009 / 2010	2010 / 2011	2011 / 2012	2012 / 2013	2012 / 2013 TARGETS
Health Link Wait Time: Percentage of calls to Health Link Alberta that are answered within two minutes.	46%	66%	78%	81%	78%	80% in 2 minutes

Sources: Health Link Alberta, Nortel Contact Centre Management 6.0

PRIORITIES FOR ACTION:
Improve patient care across the continuum (standardized clinical pathways, care plans to increase efficiency and quality).

ACTIONS	PROGRESS/RESULTS
Establish Strategic Clinical Networks (SCNs) to lead the development of evidence-based improvement.	• The Strategic Clinical Networks (SCNs) were officially launched in June 2012. • Leadership and Scientific Directors have been put in place. • Early Priority Setting initiatives underway, using AHS priority setting tools & templates. • Each SCN / Operational Clinical Networks (OCN) presented top three priorities to "Dragons' Den-like" process to receive feedback. • OCNs were launched in January 2013. These include: Critical Care, Emergency and Surgery. These OCNs are operational or service focused which differs from the SCNs that focus on a particular area of health. Each OCN will work with each of the SCNs and focus on improving standards, processes and the patient's experience within their service area. • The six remaining SCN's will be implemented in a staged fashion to guarantee engagement and success. These include: Population Health and Health Promotion; Primary Care and Chronic Disease Management; Maternal Health, Newborn, Child and Youth Health; Neurological Disease; ENT and Vision; and Complex Medicine (includes respiratory).
Obesity, Diabetes and Nutrition SCN initiatives:	• ERAS (Enhanced Recovery After Surgery): These protocols involve evidence informed nutrition management and surgical care practices that ensure a patient-centered approach and improved nutritional and physical function outcomes. • IPT (Insulin Pump Therapy) project addresses the development of IPT clinical eligibility/ineligibility criteria for children, youth and adults with Type 1 Diabetes (T1D) and identification of required AHS infrastructure across the province in response to Alberta Health's policy (Spring 2013) that would provide IPT funding for eligible persons with T1D. This project is a collaboration involving AHS, AH and the University of Alberta Health Technology Assessment Unit (HTA). • Work underway including the development of criteria for bariatric surgery procedure, an update of the HTA for bariatric surgery, a refresh of the Obesity Business plan based on updated evidence that addresses interventions across the continuum, a review of local evidence for Mind Exercise, Nutrition, Do IT program for families with overweight children with consideration for policy implementation and a poll for leading practices within AHS.
Seniors' Health SCN initiative:	• The Appropriate Use of Antipsychotics (AUA) project (in collaboration with Addictions and Mental Health SCN) focuses on reducing the use of antipsychotic medications in long-term care facilities across the province. Benefits for residents in LTC facilities include increased quality of life and reduced risk for adverse outcomes such as stroke.
Bone and Joint Health SCN initiative:	• The Fragility and Stability Program will identify and deliver prevention and promotion strategies for Albertans experiencing or at risk of experiencing osteoporosis-related fractures. The program will also improve supports to those experiencing hip fracture, with the goal of shortening the amount of time these patients spend in acute care settings and returning patients to independent living.
Cardiovascular Health and Stroke SCN initiatives:	• Vascular Risk Reduction identifies people at risk for vascular disease who are undiagnosed, diagnosed and not well managed as well as to provide risk screening and management services in accessible community locations and efficient specialty clinics. • Stroke Action Plan addresses the quality of and access to stroke care in rural and small urban stroke centres across Alberta. This project will determine and implement the components of stroke care in rural regions that are most associated with improved patient outcomes and reduced death and disability; and facilitate early discharge from acute care by delivering expert stroke rehabilitation into client's homes through early supported discharge. Identification of best practices for rural/small urban centres underway, in partnership with Alberta experts, Canadian Stroke Network and representatives from BC and Manitoba. First of 14 sites recruited (St. Mary's in Camrose) and implementation planning is underway to enhance both in-hospital and after discharge care to patients in this area who have sustained a stroke.
Cancer Care SCN initiatives:	• Clinicians within Cancer Care have developed and implemented standardized provincial referral and triage guidelines for patients with a cancer diagnosis for the following tumour groups: breast, gastrointestinal, lung, neurooncology, hematology, genitourinary, gynecology, cutaneous, sarcoma, head and neck, endocrine, bone marrow transplant, as well as for pain and palliative care. • Work will begin on automating referrals to Cancer Centres commencing with lung and breast cancer. This project will standardize the referral process for patients across all zones and test new e-referral technology with the future view of this being rolled out across the remaining tumour groups. Completion of this work will result in better access to cancer treatment for Albertans.

PRIORITIES FOR ACTION:
Improve patient care across the continuum (standardized clinical pathways, care plans to increase efficiency and quality).

ACTIONS	PROGRESS/RESULTS
Addiction and Mental Health SCN Initiatives:	• Established an Addiction Research Network which has representatives from academia (researchers) and AHS clinicians which has a working group on alcohol use disorders. • Clinical pathways have been developed for adult depression which will focus on the primary care environment and support the provision of short term psychosocial interventions. • An adolescent depression clinical pathway was developed and piloted with an initial focus on outpatient mental health clinics with linkages to primary care and additional referral sources. Findings from the pilot will be used to expand the adolescent pathway to incorporate prevention and early intervention into a more integrated care pathway.

In Summary: Strategic Clinical Networks (SCNs) are working to reshape health care in different areas of health to help AHS and its zones provide a patient-focused, quality health system that is accessible and sustainable for all Albertans. To help reshape health care each network will work towards: improving the patient experience; ensuring care is available when it's needed; putting strategies in place to keep Albertan's healthy; and providing Albertans with the best health care for generations to come.

As a provincial health care system, AHS has the opportunity to learn from and share best practices all across the province. We also have the opportunity to work together to develop new and innovative ways of doing things that can be shared province-wide.

As SCNs move forward, they will expand and integrate into the work we do and the care we provide every day. This will help us to learn more about what's working, what can be done to make it work better, and identify what's not working.

PERFORMANCE MEASURE	2011 / 2012 Q3	2012 / 2013 Q3
All cause 30 day readmission rates	8.1%	8.3%
Percent of inpatient days identified as ALC	Development of common definition. To be reported in 2013-14.	
Actual hospital days compared to expected length of stay	Development of common definition. To be reported in 2013-14.	

Source: AHS Health Information Management and DIMR.

PRIORITIES FOR ACTION:
Increase system capacity to support access to services.

ACTIONS	PROGRESS/RESULTS
Expand and/or develop numerous health facilities in communities around the province.	• Starting with the Emergency Department, a few clinics and 113 inpatient beds, patient care opened at the **South Health Campus (SHC)** in Calgary. The remaining inpatient units will open in waves until Fall 2013. The new hospital will treat about 60,000 patients in its first year. SHC will redefine the way health care is delivered within the community by integrating leading technology, research and education with unique healing environments and progressive environmental design. It will include a broad range of inpatient and outpatient services, with a focus on wellness services and facilities. These wellness services will make illness prevention, management and community health education an important focus of the campus. • The **Kaye Edmonton Clinic** brings a wide range of outpatient services under one roof, including orthopedic, day surgery, family medicine and seniors clinics. When fully operational, nearly one million patients a year will benefit from this integrated network of care located all in one place. • AHS opened a new hospital in Fort Saskatchewan in April 2013 with more than triple the space of the existing facility. The new **Fort Saskatchewan Community Hospital** will offer 32 acute-care beds, with capacity for expansion to 38, and 24-hour emergency services. Additional services offered at the new Fort Saskatchewan hospital will include: IV Therapy Clinics, Obstetrics, General Surgery, Ophthalmology including cataract surgery, Radiology, Rehabilitation, Pharmacy and Laboratory Services. It will also include space for consolidation of specialized community health services, including Home Care, Public Health, Addiction and Mental Health, Community Respiratory Therapy, Audiology and Rehabilitation Services. • **Stollery Children's Hospital** in Edmonton has expanded and separated the Stollery's emergency department (ED) from the University of Alberta Hospital. It provides a separate ambulatory entrance for patients and their families, along with a separate child-friendly waiting room, triage area, registration area, a new family consultation room, enhanced work space for the pediatric emergency physicians and a trauma room. Nearly 28,000 pediatric emergency department visits were made to the Stollery Children's Hospital last year, the newly expanded ED is built to accommodate up to 35,000 visits per year. • The **QEII Hospital Emergency Department** in Grande Prairie saw its first patients in its newly renovated space in April 2012. The renovation and expansion project, started in 2010, will roughly double the space of the original ED, which was built in 1984 to handle 22,000 visits per year. It is currently handling about 50,000 visits annually. • Existing space is being redeveloped in Medicine Hat, Lethbridge and Fort McMurray, and new facilities are being built in Sherwood Park, Red Deer, Grande Prairie and Edson. Radiation therapy treatment facilities are being constructed in Red Deer and Grande Prairie.

Provide More Continuing Care Options

By 2030, one out of five Albertans will be more than 65 years old and the average age of Alberta's population will continue to increase. Many seniors will be more independent and healthier than in previous generations. Others, including those with multiple chronic illnesses and disabilities, will need health care and will want options that allow them to receive care while continuing to live in their own homes and communities.

PRIORITIES FOR ACTION: **CONTINUING CARE**

Provide Albertans with more options to "age in the right place" by enhancing support services and offering more choice and care options to Albertans in their homes and communities.

ACTIONS	PROGRESS/RESULTS
Add over 1,000 continuing care spaces in 2012-13.	• 1,155 continuing care beds / spaces opened in 2010-2011. • 1,002 continuing care beds / spaces opened in 2011-2012. • 877 continuing care beds / spaces opened in 2012-2013. Achieved 88% of target of 1,000 beds opened. Key reasons why target 1,000 new continuing care beds/spaces was not achieved in 2012-13: building project delays, building code requirements and provider initiated bed/space closures. • The above additions have resulted in 3,034 net new continuing care beds in the three year period from April 1, 2010 to March 31, 2013.
Work with AH to develop two continuing care centres demonstration projects.	• Two Covenant Health pilot sites are under construction. Zones and Covenant Health worked collaboratively together to determine the types of services that will be provided at the sites guided by the principles of continuing care centres.
Expand home care by adding more hours to prevent hospitalization.	• AHS continues to expand home care by adding more hours for those requiring short-term care in order to prevent hospitalization or an emergency situation. In total for 2012-13, AHS had 108,855 home care clients across the province. All zones will be implementing the new service guidelines and educating staff to the new guidelines. Opened 60 new adult day program spaces to delay clients' need for admission and to provide assistance to the clients' caregivers. Destination Home continues to increase home care services to clients with complex needs in Calgary and Edmonton.
Expand palliative care beyond the hospital to provide more services in the community.	• 20 hospice beds were opened in 2012-13. • Partnered with Cancer SCN, Seniors SCN, and zone end of life and palliative programs to further the end of life/palliative strategy development and implementation.
Increase dementia care spaces.	• 311 Supportive Living Level 4 dementia spaces were opened in 2012-13.
Develop AHS wide approach to support mental health patients in congregate living settings.	• Addiction and Mental Health and Seniors Health working group initiatives continue related to a supportive housing framework and defining required health and support services.
Develop AHS wide systematic and consistent best practice in Advanced Care Planning/Goals of Care Designation process, including for palliative care.	• Standardized Advanced Care Planning (ACP) and Goals of Care Designation implementation in process with zone and acute care education. ACP offers a system-wide approach to assist clinicians and patients in discussing and defining the goals of care for individuals receiving health care services. A Conversations Matter guidebook, videos, as well as a toolkit is available to enhance and support advance care planning and health care decision making for patients, families and health care providers.

In Summary: AHS continues to expanded seniors' living options across the province, confirming our commitment to provide the right care in the right place. For those able and wanting to continue to live in their own homes, AHS has made significant investment in home care and other services and programs that keep people safe and healthy in their homes, including after discharge from hospital.

PERFORMANCE MEASURE	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	2012 / 2013 TARGETS
Number of People Placed into Continuing Care					
Number of patients **placed from acute / subacute** hospital bed into continuing care placement	n/a	4,951	5,355	5,561	n/a
Number of clients **placed from community (at home)** into continuing care placement	n/a	2,087	2,345	2,200	n/a
TOTAL Number of People Placed into Continuing Care	**n/a**	**7,038**	**7,700**	**7,761**	**n/a**
Number of People Waiting Continuing Care Placement as of March 31st					
Number of persons **waiting in acute / subacute** hospital bed for continuing care placement	707	471	467	453	350
Number of persons **waiting in community (at home)** for continuing care placement	1,039	1,115	1,002	701	850
TOTAL Number Waiting For Placement	**1,746**	**1,586**	**1,469**	**1,154**	**1,200**
Wait Time for Continuing Care Placement					
Average wait time in acute / subacute care hospital bed for continuing care placement	54 days	54 days	41 days	34 days	30 days (2015 targets)
Percent of patients placed in continuing care within 30 days of being assessed	n/a	55%	64%	67%	n/a
Number of Home Care Clients					
Number of unique home care clients	n/a	97,326	104,089	108,855	Increase by 3,000

Source: AHS Seniors Health, DIMR, AHS "Snapshots" of the waitlists as of March 31st for number of people waiting.

Strengthen Primary Health Care

Primary health care is said to be the front door to health care as an individual's first point of contact with the health system is often a visit to the family physician. The case for primary health care is well established: stronger primary health care leads to better health outcomes and more efficient health care delivery.

With our aging population and chronic disease on the rise, it is imperative Albertans have access to the best primary health care system. This will help them maintain good health and access the services they need, when they need them. Support is also needed for individuals with addiction and mental health neds or complex chronic conditions and for vulnerable children and seniors through coordinated services provided by a primary health care team.

PRIORITIES FOR ACTION: **PRIMARY CARE**
Apply and advance a patient-focused model of primary health care that offers care in the community, and provides a team based provider approach.

ACTIONS	PROGRESS/RESULTS
Developing a primary health care plan which builds on 2011-12 access initiative planning, and includes a focus on individual- and family-centred, team-based care.	• AHS staff from Primary Care Innovation & Integration (PCII), as well as leads from Primary Care and Chronic Disease Management (CDM) in all five zones, continue to work with Alberta Health to develop planning and background material for the launch of the first wave Family Care Clinics (FCCs). Following the announcement from the Minister on the number and location of FCCs in the province, work to develop FCCs to meet the health needs of selected communities will begin. • Three pilot FCC sites in Edmonton, Calgary and Slave Lake have been open for almost one year and continue to provide better access to populations identified as having higher needs for primary health care as well as issues with access.
Continue to develop and expand the myhealth.alberta.ca personal health portal to provide secure online access to personal clinical health information and personalized tools that enhance access to the health system.	• Recently launched site from the Government of Alberta and AHS, MyHealth is an evolving, trusted web resource for Albertans who want to know more and do more about their personal health and well-being. MyHealth covers over 8,750 health topics, including medication and medical test information, health alerts, health service locations, and smart features, such as a symptom checker. As well, it offers tips and resources on personal wellness and specific health conditions to help you live a healthy life. The site's clinical content and features are reviewed by Alberta physicians, nurses, dietitians, chiropractors and many other health professionals. Recent additions and changes to the site include a new and improved look of the layout and organization of content making it easier to find information. The new website design highlights important information and allows for the addition of new sections as the site grows. Albertans can also browse over 130 health videos, and that number will continue to grow. The videos cover diverse topics and add a new dimension to learning about health topics. Visits to the site have ranged between 94,000-99,000/month. A total of 354 new content topics were added to the site in 2012-13.
Help Albertans manage chronic disease and maintain healthy weights.	
Improve care for Albertans with complex, chronic conditions by: Continuing to implement provincial obesity program pathways for adults and pediatrics within each zone, continuing the development and implementation of primary care clinical pathways.	• Development of core service components within the pediatric care pathway continues along with the development of the first phase of supporting tools and resources for both primary and specialty care. Stakeholders are engaged through a variety of mechanisms for validation of approach and need for tools/ resources within public health, primary care, and specialty care. Zone consultations for implementation are complete and training and communication plans have begun. Zones are using the provincial pediatric model of care as a framework for their pathway development and implementation. Pediatric model undergoing some revisions to better align with needs of primary care. • Mind, Exercise, Nutrition; Do it (MEND) prevention program for children piloted in a number of communities and with different age groups. The Aboriginal program pilot is complete and the data is being analyzed.
Developing and expanding specialty care capacity for complex management of bariatric patients in Grande Prairie (adult) and Calgary (pediatric).	• The adult obesity specialty clinic in Grande Prairie (opened in May 2012) has secured space and is experiencing an increased number of new referrals. Surgical consults are sent to the Edmonton specialty clinic. • Adult obesity specialty clinics in Edmonton, Red Deer, Calgary and Medicine Hat continue to provide multidisciplinary care for obesity management. The Provincial Bariatric Resource Team continues to provide clinical support in obesity management across the province, including the development and delivery of educational resources for patients and health care providers. • The pediatric specialty care clinic at the Alberta Children's Hospital is accepting referrals and receives ongoing training/clinical support from the Provincial Bariatric Resource Team. A common referral form is in use in the Calgary Zone for receiving specialty referrals.

PRIORITIES FOR ACTION: PRIMARY CARE

Apply and advance a patient-focused model of primary health care that offers care in the community, and provides a team based provider approach.

ACTIONS	PROGRESS/RESULTS
Establishing a research framework for evidence-based obesity health service delivery.	• Collaborative Research work is ongoing on three externally funded studies: ◦ Working with Parents to Prevent Childhood Obesity: A Primary Care-Based Study. ◦ Evaluating Self-Management and Educational Support in Extremely Obese Patients Awaiting Multidisciplinary Bariatric Care (EVOLUTION). ◦ Understanding Pediatric Obesity Using a Biomedical, Interventional and Program Evaluation Approach. • Evaluation ongoing for the Obesity Program, Adult Obesity Specialty Care Program, Pediatric Obesity Specialty Care and within Primary Care Networks (PCNs) regarding obesity prevention and management.
Continuing to develop chronic disease management (CDM) teams and provider training.	• The development of vascular risk reduction courses (CDM of hypertension and dyslipidemia) is complete. These courses have been launched on My Learning Link (MLL) for AHS staff and an external learning management system (LMS) for non-AHS partners. • Chronic Obstructive Pulmonary Disease (COPD) online course redevelopment has been completed. The new version of this course is available on MLL and on external LMS. • Redevelopment work for the CDM 101 online course continues.
Continuing to develop targeted obesity and CDM services for Aboriginal residents and other diverse populations across the province.	• Capacity is building within the zones through training of diversity competency workshops in their zones and among stakeholders. • A comprehensive Diversity Competency Toolkit was developed and disseminated to support the zones in delivery of the diversity workshops. • Diversity teams in the zones continue to engage with diverse and vulnerable communities. Edmonton Zone piloted a Better Choices, Better Health program for HIV positive patients. Elbow River Healing Lodge clinic is offering CDM services to urban Aboriginal people in Calgary. A Brooks Community Needs Assessment Report has been completed. Program expansion to Hutterite communities in the South Zone has begun. • The provincial Targeted CDM Approaches for Diverse and Vulnerable Populations in Alberta Framework is being implemented in a number of health care settings.
Targeted communication in 2012-13 related to: tobacco cessation, low risk drinking, healthy eating and active living.	• Three workplace organizations are developing sustainability strategies for the walking program. PepsiCo, in Taber Alberta, has formed a Wellness Committee, which will include employees. In addition, PepsiCo's Lethbridge plant will conduct a walking challenge. The South Health Campus at AHS will also maintain and expand their Wellness Committee to include employees from different disciplines. To initiate improvement to promoting walking at the organizational cultural level, senior management from these workplace sites have completed a workplace audit tools which will be shared with the organizations once available.
Improve the quality and delivery of primary health care.	
Implement the provincial primary health care plan, including implementation of a plan for chronic disease prevention and management.	• The Primary Health Care Plan is led by Alberta Health and is currently at their strategic planning table.
Reduce health gaps in rural areas and among vulnerable populations in the North and South Zones.	• Aboriginals benefited from a renal outreach prevention clinic on the Siksika reserve near Calgary to help people at high risk of developing chronic kidney disease. The community of Siksika has the highest prevalence of diabetes in Alberta. The clinic, developed by the Southern Alberta Renal Program (SARP) targets high-risk patients: people with diabetes, high blood pressure, high cholesterol and/or protein in their urine. The Northern Alberta Renal Program (NARP) runs similar clinics in towns across northern Alberta, none targeted specifically to First Nations communities. • Implementation of targeted obesity/chronic disease management (CDM) programs for Aboriginal population (in three Métis settlements and High Prairie) in the North Zone is in progress. • The South Zone is focusing on program development for refugee and high risk visible minorities in the Brooks area. Program expansion to rural Hutterite communities has begun.
Develop and document best and promising practices for primary care and chronic disease management programs for homeless and other diverse and vulnerable populations.	• A comprehensive review of best and promising primary care and CDM practices for the homeless and other vulnerable populations has been completed which identified successful strategies and approaches. These strategies and approaches were used as a foundation for development and implementation of a provincial framework for quality and delivery improvement for diverse and vulnerable populations in Alberta.

In Summary: AHS continues to focus on strengthening access, quality and sustainability of primary care services to improve the health and wellness of all Albertans by:

- shifting emphasis from treating illness to creating health and wellness.
- helping individuals to be proactive about their own health.
- implementing team-based approaches to providing primary care through Primary Care Networks and Family Care Clinics.
- providing unlimited access to Health Link Alberta and www.myhealth.alberta.ca.
- working with other primary care providers, to help individuals manage chronic illness through patient education, exercise and self-management strategies.
- integrating addiction and mental health support into primary care services throughout Alberta.

PERFORMANCE MEASURE	2008 / 2009	2009 / 2010	2010 / 2011	2011 / 2012	2012 / 2013	2012 / 2013 TARGETS
Ambulatory Care Sensitive Conditions: Rate of hospital admissions for health conditions that may be prevented or managed by appropriate primary health care.	297.3	298.3	292.7	290.9	296.4	282
Family Practice Sensitive Conditions: Percent of emergency department or urgent care visits for health conditions that may be appropriately managed at a family physician's office.	28%	27.4%	27.5%	26.4%	26.0%	23%

Source: AHS Discharge Abstract Database and Provincial Ambulatory (ED/Urgent Care) Abstract Data

PRIORITIES FOR ACTION: CHILDREN'S MENTAL HEALTH

Improve the availability and accessibility of addiction and mental health services for Albertans in community settings, especially services for children and youth.

ACTIONS	PROGRESS/RESULTS
Implement the following to support the addiction and mental health strategy. Post partum depression screening	• This work connects to the Alberta Perinatal Health Strategy. Within AHS, this initiative will standardize prenatal and at-birth screening, referral and treatment for mothers, including those "at risk". • The Edinburgh Postpartum Depression Scale is used by Public Health across the province and an environmental scan highlighted that there are some differences between when, how, where, and why mothers are being screened across the zones.
Defining a basket of fundamental services for addiction & mental health.	• The goal of this project is to improve the quality of life for clients/patients and families by enhancing the capacity of community-based Addiction and Mental Health services and improving effectiveness of specialized and inpatient care.
Expanding tele-mental health.	• The goal is to expand capacity and utilization through increased awareness of services, development of end user support resources, expansion of sites, etc. • Telehealth equipment has been replaced or refreshed at 40 sites across zones and areas of priority need. Telemental Health/Telepsychiatry current state assessment and analysis near completion with planning underway to develop the future state.
Developing a housing and supports framework.	• This project entails partnership with ministries, stakeholders and service providers to facilitate ready access to a range of housing options and community supports. Initiatives include: Housing Framework, Housing and Services Gaps & Community-Based Tertiary Rehabilitation & Services. • The Housing Capacity for Vulnerable Albertans project was approved. This project is a cross-ministry initiative that will be designed to address housing and support needs for up 150 homeless vulnerable Albertans.
Developing a plan to address the needs of complex persons with developmental disabilities.	• This project focuses on the five policy elements identified in the Supports for Adults with Complex Service Needs Cross-Ministry Policy Framework, October 2011. • Community Support Teams within each of the zones are being established.
Continuing implementation of the Children's Mental Health Plan (CMHP) and the Positive Futures Framework, including school based mental health capacity building approaches.	• The Children's Mental Health Plan supports a coordinated and collaborative approach to optimizing the mental health and well-being of infants, children and youth up to 24 years of age, and their families. AHS has begun implementation of the 23 actions identified in the plan across all five zones in Alberta. • Children's Mental Health programming is underway in nine PCNs. • Positive Futures planning underway to support the selection and development of an implementation plan for a minimum of three of the five recommended standards. • Mental Health Capacity Building in Schools Initiative: Projects funded by the expansion grant continue on track and on budget. The 12 projects CMHP projects are set to end on June 30, 2013, while the expansion grant projects will end on June 30, 2014. Discussion regarding the sustainability of the 12 CMHP projects has been initiated.
Increase provincial Protection of Children Abusing Drugs Program in services system.	• The Protection of Children Abusing Drugs Act (PChAD) helps children under 18 years of age whose use of alcohol or drugs is likely to cause significant psychological or physical harm to themselves or physical harm to others. AHS offers a number of programs to assist children and their families with drug and alcohol-related issues.

In Summary: A comprehensive Alberta's Addiction and Mental Health Strategy was released. Over the past year, significant work has been implemented to improve addiction and mental health delivery systems for all age groups. Although there are many ways to measure and monitor the progress in improving mental health services, emphasis has been on children's mental health. The chart below indicates slight improvement from last year in access to children's mental health services, however we are not yet achieving target. This is attributable to challenges in specific areas in the province as well as data collection issues. Efforts have been focused at zones which remain below target for the performance measure related to children's mental health services access and will continue in the upcoming year.

PERFORMANCE MEASURE	2010 / 2011	2011 / 2012	2012 / 2013	2012 / 2013 TARGETS
Wait Time for Children's Mental Health				
Percent of children aged 0 to 17 years receiving scheduled mental health treatment within 30 days.	75%	76%	80%	92%

Source: AHS Mental Health Services

4. Promote and Protect the Health of the Population in Alberta and Work Toward the Prevention of Disease and Injury

AHS is developing a collaborative approach within the organization and with other partners to reduce health inequities. This work includes strengthening capacity, enhancing knowledge development, exchange and translation, and undertaking targeted action. Increasing our focus and effort on health equity is seen to be a strong contributor to achieving transformational improvement in the area of staying healthy and improving population health and in supporting overall system sustainability.

Together, AHS and Alberta Health have established a strong agenda for improving the health of all Albertans through a focus on wellness, health promotion, and disease and injury prevention, including chronic disease prevention. AHS will work collaboratively with Alberta Health and others to more fully define all of the actions required in this arena, with joint planning activities being undertaken during 2012-13.

PRIORITIES FOR ACTION: **POPULATION HEALTH**
Improving immunization rates.

ACTIONS	PROGRESS/RESULTS
Develop and begin implementation of a coordinated plan to increase childhood immunizations and improve infrastructure and reporting supports to this work. This includes: survey of parents of immunized and unimmunized children to determine barriers to immunization; review of rates of immunization for children; explore options for new consent process.	• All zones implemented and had success with immunizing all family members, who presented with an infant or child to a child health clinic. This was done through the use of an additional nurse to offset the possibility of increased clients. • Phone recall reminders (autodialer) were made to families with young children to receive their flu vaccination at a community health centre. • Different approaches were used to deliver vaccine to community partners this season. For example on one zone, after-hour influenza clinic appointments were accepted for parents/guardians with children, resulting in positive feedback from families. • Positive feedback was received from over 1,600 community partners providing influenza immunization in the 2012-13 program. • Results of the front-line staff 'barriers to immunization' survey are being analyzed by zone and by program. Results will be used to develop strategies to increase immunization rates in each zone and across the province. • Work continued on participating in the "Alberta Immunization Strategy Refresh" project to move immunization strategies for the future forward.

PERFORMANCE MEASURE	2009 / 2010	2010 / 2011	2011 / 2012	2012 / 2013	2012 / 2013 TARGET
Rates of seasonal influenza immunization by age group:					
Children aged six to 23 months	16.0%	27.0%	29.9%	30.2%	75%
Adults aged 65 years and older	55.6%	58.9%	60.8%	60.0%	75%

PERFORMANCE MEASURE	2007	2008	2009	2010	2011	2012	2012 / 2013 TARGET
Rates of childhood immunization by two years of age in all service zones:							
diphtheria/ tetanus/ acellular pertussis, polio, Hib	83.7%	83.8%	77.0%	73.1%	74.4%	72.6%	97%
measles/ mumps/ rubella	88.5%	89.3%	86.7%	85.7%	85.5%	84.3%	98%

Sources: Alberta Health and Alberta Health Services

Above Influenza Immunization Rate based upon the influenza season and therefore considers doses delivered from October through to April 30th. The rate up to March 31st was 60.0% for Seniors (aged 65 and older) and 29.5% for Children (aged 6 to 23 months).

PRIORITIES FOR ACTION: **POPULATION HEALTH**

Improve population health through the integration of health promotion, disease and injury prevention and screening programs with other health care delivery services as well as better co-ordination between health, government, municipal and other sectors.

ACTIONS	PROGRESS/RESULTS
Child and maternal health Introduce and support new programs to fight obesity and promote healthy weight and physical activity in children and youth. Adapt and pilot "Mind, Exercise, Nutrition – Do It" MEND 2-4, MEND 5-7, MEND 7-13 in a minimum of 10 Alberta Communities, including one First Nations reserve and one Métis settlement by March 2013.	• More than 60 families have received weight-management support for their children at the Pediatric Centre for Weight and Health, located within Alberta Children's Hospital. The Centre brings together a team of specialists – including pediatricians, nurses, exercise specialists, registered dietitians, social workers, outreach coordinators and patient care coordinators – to help youth between the ages of two and 17 years to reach and maintain a healthy weight and lifestyle. Nearly 220,000 Albertans ages 2 to 17 are either obese or overweight. Families with children who have weight-management issues are referred to the centre through a physician or nurse practitioner. • Work continues to improve population health through integrating health promotion and disease and injury prevention programs with other health care delivery services, and better coordination between health and other government and municipal sectors. The pilot MEND program is designed to fight obesity and promote healthy weight and physical activity in children and youth. Up to 47 MEND programs are being delivered across all five zones, including one First Nations reserve and one Métis settlement. Fourteen community partners have been engaged in program delivery, with programs operating out of 18 sites across 5 zones. Findings have been very positive to date and highlight support for MEND in the community by service delivery agencies, program participants and their families.
Health promotion/ prevention components of the provincial obesity program, which includes work with primary health care providers.	• Resources and tools have been developed and disseminated to over 5,000 health care professionals working with pregnant women in Alberta. • Surveys were disseminated provincially to assess women's and health care providers' knowledge, attitudes and behaviours related to pregnancy weight gain, nutrition and physical activity. Work commences on data analysis.
Framework to support healthy childhood development in collaboration with Alberta Health and other ministries.	• Approval has been obtained from the government to move forward on implementing the Infant and Preschool Screening and Follow-up Services Framework. The framework outlines two main screening pillars: universal newborn hearing screening (UNHS) and developmental screening. The initial focus for the Government of Alberta next fiscal year will be newborn hearing screening, which will be phased in over a period of time to ultimately become universal. This work will begin in early 2013 while formal work on developmental screening is anticipated to begin late fall of 2013.
Standardized provincial resources for parents and professionals on early childhood development and safe infant sleep.	• The safe infant sleep staff training module has been finalized. An AHS Safe Infant Sleep policy has been developed in collaboration with AHS Clinical Policy. Final endorsement and sign-off of the policy, implementation plan and evaluation plan are anticipated by April 2013. Training materials and resources are being finalized. Implementation of the policy will occur in June 2013. Initial consultation with Aboriginal services has been initiated to discuss possible Aboriginal adaptations of these resources.
Standardized provincial prenatal and early postnatal education resources.	• The provincial prenatal and early postnatal resource was disseminated for feedback and is currently being printed.
Continue collaboration with Alberta Health to develop strategies to increase breast feeding initiation and duration rates and to develop the perinatal health strategy.	• This is a joint initiative in collaboration with Alberta Health under the umbrella of the Maternal Infant Health Strategy. • Work has been completed to determine breastfeeding strategies, policies, targets, and related outcomes in countries similar to Canada. • Action items to increase breastfeeding rates have been identified as part of the Maternal Infant Health Strategy. AHS will lead some of these actions once the Strategy has been approved by the Minister and funding has been identified.
Prevent injuries and disease Support targeted areas of actions identified in the Alberta Traffic Safety Plan to reduce the risk of injury and death across Alberta including occupant restraint, distracted driving and impaired driving.	• AHS child safety seat web content for the public is being transitioned to myhealth.alberta.ca. • AHS is providing input into the redevelopment of the Alberta Occupant Restraint Program website (www.albertaseatbelts.ca), development of Human Services interactive training module on child safety seats, and revisions to child safety seats provincial resources for the public (focus on plain language and updating of images). • Child safety seat print resources were made available. These resources are used by AHS staff, police and other injury prevention stakeholders across the province. Electronic versions are also posted on the Alberta Occupant Restraint Program website and AHS "For Health Professionals" area of the provincial injury prevention website.

PRIORITIES FOR ACTION: POPULATION HEALTH

Improve population health through the integration of health promotion, disease and injury prevention and screening programs with other health care delivery services as well as better co-ordination between health, government, municipal and other sectors.

ACTIONS	PROGRESS/RESULTS
Continued implementation of "A Million Messages".	• The A Million Messages (AMM) provincial online learning module, an educational resource for professionals, was launched on the AHS public website along in January 2013. The AMM program content is applicable to a broad range of injury mechanisms including falls, transportation and intentional injuries. The online module includes an evaluation component which addresses increased knowledge, participant satisfaction, and program usability. • Safe and Sound is a computerized program that allows parents/caregivers the opportunity to enter information regarding their child (ren)'s age and living environment to receive injury prevention messages tailored to their situation. A printed report provides information for the health professional, the parent and any caregivers. The Child Injury Prevention computer kiosk programs are available in the zones and in two provincial children's hospitals. • HUTV, Health Unlimited Television, in partnership with AHS & Health Link Alberta, provides free general health and wellness programs customized for waiting room screens and health facilities. Arrangements have been made for HUTV to provide television streaming of injury prevention messages in various health services locations across Alberta.

Development of a teen injury risk management approach.	• Smart Risk Professional Series, a core AHS injury prevention resource for professionals, was distributed to stakeholders and posted on AHS website.
	• The AHS approach for teen risk management will have Smart Risk as its foundation. This will allow those working on the frontline to do the following:
	  • address three main injury issues for youth - transportation, suicide, and sports
	  • build risk recognition and risk management decision-making skills among teens and their parents
	  • provide programming that is evidence-informed and consistent with adolescent development and theory (e.g., injury prevention statistics, adolescent brain development, protective factors, resiliency, social norms)

Implementation of AHS Fall Risk Management Framework.	• Development of fall prevention posters for parent and staff education was finalized for Alberta Children's Hospital (ACH) in Calgary in consultation with ACH Fall Risk Management program staff. Stollery Fall prevention campaign is continuing.
Continue to increase supports for Albertans to quit using tobacco.	• QuitCore is a free group support program that provides Albertans the tools and skills they need to quit using tobacco. In Alberta, 20 sites across the province offered QuitCore. • Central registration through HealthLink/AlbertaQuits was implemented, tested and fine-tuned and a manual registration process developed for participants who do not pre-register. • Launched in December 2012, AlbertaQuits.ca is an internet-based cessation service for Albertans who use tobacco and wish to access cessation resources and on-line support. • Curriculum for high school students on alcohol and health decision making has been developed and is available to Albertans. • Communication strategy developed, media launch occurred via twitter in December 2012. Completed three TV interviews, (City, CTV, Global) and one radio interview in December. • With the launch of the enhanced site, there is a 200% increase in people accessing the site this quarter. The most popular new services are e-quits tips and albertaquits by text. • The Tobacco Free Futures health system model supports health care settings across the province to integrate tobacco treatment as a standard of care through process and resource development, staff training, and treatment linkages. • Supported Alberta Health in implementation of the Champix Supplementary Health Plan.
Increase prevention and improve early detection and diagnosis.	• Partner Notification Nurses (PNN) started physician/clinic visits to promote Sexually Transmitted Infections (STI) screening and build awareness of the STI Program. Visits include: reviewing the notification process, distribution of STI materials (i.e., STI medications, treatment guidelines, distribution of condoms, etc.). • Packaging of STI medications has been redesigned in order to accommodate the new STI treatment guidelines and to allow the addition of condoms to the packages.
Enhance management and control of STI and blood borne pathogens.	• Work continuing on increasing awareness about the change in treatment recommendation for gonorrhoea - in response to concern about drug resistance. • In February 2013, Alberta Health mailed the new guidelines to physicians and posted the new treatment guideline on their website.
Strengthen support and counselling for those infected and affected.	• STI Services has collaborated with AH on revising the "Taking Care of Yourself and Others" pamphlet which is a helpful resource in patient teaching.

PRIORITIES FOR ACTION: **POPULATION HEALTH**

Improve population health through the integration of health promotion, disease and injury prevention and screening programs with other health care delivery services as well as better co-ordination between health, government, municipal and other sectors.

ACTIONS	PROGRESS/RESULTS
Strengthen infrastructure to support the STI and BBP Action Plan.	• Work resumed on the proposed STI organizational structure to work on recommendations of the Alberta Health Sexually Transmitted Infections and Blood Borne Pathogen (BBP) Strategy and Action Plan 2011-2016 as well as the AHS STI BBP 5 Year Action Plan. • The first edition of the STI newsletter was disseminated in November to all STI staff, physicians and partners to highlight the work being done on the Action Plan. • Monthly surveillance reports continue.
Redesign and update of content in the teachingsexualhealth.ca website for parents and teachers.	• The redesign and content updates for the teachingsexualhealth.ca website (for both the parent and the teacher portals) have been completed. • Eleven lesson plans have been translated into French.
Continue to develop AHS emergency preparedness strategy/plans and assess readiness.	Business Continuity Management (BCM) – Phase I Measure: • Magnitude and necessary requirements for implementation of a BCM program within AHS was identified. A BCM survey was completed by AHS Executive. A final report was prepared that summarized the findings. Approval to move forward on Phase II was granted. Mass Casualty Incident (MCI) Planning underway. Pandemic Planning: • Approximately 79% of HQCA recommendations for AHS-only completed; when linked with Alberta Health, approximately 49.5% are addressed. • Approximately 85% of the Internal Audit recommendations relative to AHS-only have been addressed; when linked to Alberta Health, approximately 55% have been completed. • Alberta Pandemic Influenza Plan released by AH for review from AHS in March 2013. Chemical, Biological, Radiological, Nuclear (CBRN) Program Roll-out: • Fire training e-learning module developed and loaded to MyLearning Link. • The CBRN Self Study module converted to e-learning module and loaded to MyLearning Link. Reprint of CBRN Self Study Modules to support training of contracted providers, such as Covenant Health. • E-learning modules for "Introduction to Codes Brown, Blue, Black, Orange, Gray, Green, Yellow, and White" developed and loaded to MyLearning Link. Code Purple e-learning module completed. • For 2012-13 fiscal year, approximately 26,000 modules completed with >6000 currently active registrants. • Training commenced in Central, Edmonton and North Zone for staff working in AHS Acute Care Emergency Departments and Urgent Care Centers. • "Train the Trainer" Program delivered to Zone Emergency/Disaster Management Department (EDM) staff in all zones. The program will transition to EDM in the Zones in April 2013.
Continue to implement newborn metabolic screening standards across AHS.	Newborn Metabolic Screening (NMS) Program Initiative developed the following components for an organized population-based screening program: • NMS Program clinical policy suite (implementation planned for mid 2013 as level 1 policy). • NMS Program partnerships with Alberta Health and Health Canada – First Nations • Inuit Health Branch (FNIHB), Alberta Region (transition to ongoing program coordination). • NMS Program information and education for parents, AHS staff, and physicians and midwives, performance management, patient safety, business continuity, functions and integration, and quality management and improvements are transitioning to ongoing program coordination in the spring.
Develop a post partum depression screening tool and protocol as part of the AH/AHS Addiction and Mental Health Strategy.	• Facilitated joint planning between the government of Alberta and AHS in the development of resources, programs and services related to post partum anxiety and depression and to ensure alignment with Alberta's Addiction and Mental Health Action Plan. • Task groups were formed to complete the following deliverables: complete an environmental scan for referral and treatment, determine screening/assessment and surveillance processes and develop data collection and reporting recommendations.
Continue to develop education and awareness tools to prevent chronic diseases. Develop/adopt targeted and socio-culturally appropriate education and awareness tools for prevention and management of chronic diseases for diverse and vulnerable populations.	• Mind, Exercise, Nutrition; Do it (MEND) prevention program for children piloted in a number of communities and with different age groups. Aboriginal program pilot complete and the data is being analyzed.

PRIORITIES FOR ACTION: **POPULATION HEALTH**

Improve population health through the integration of health promotion, disease and injury prevention and screening programs with other health care delivery services as well as better co-ordination between health, government, municipal and other sectors.

ACTIONS	PROGRESS/RESULTS
Completion of an Aboriginal Cancer/Chronic Disease Resource Manual funded by the Alberta Cancer Prevention Legacy Fund.	• Supported by the Alberta Cancer Prevention Legacy Fund, the Aboriginal Health Program worked in partnership with Cancer Care to hold three workshops across the province to better understand the barriers and challenges for Aboriginal people to accessing cancer screening and cancer care. A resource manual is available to assist AHS programs and services to better understand Aboriginal people, their diverse cultures, and some of the challenges that have led to health disparities particularly related to chronic diseases.
Advocate for policies that promote a healthier society.	• The Built Environment Health Promotion Strategy (BEHPS) Strategic Directions document and indicators report are completed. Six zone engagement workshops were conducted. • AHS worked with national and international organizations (including Walk 21, Green Communities Canada) to develop strategies to improve the walkability of Alberta communities. Using interactive community workshops and based on the International Charter for Walking, communities developed action plans to overcome barriers and address issues that impacted walking in their communities. Five communities across four zones participated and they are currently implementing their action plans.
Work collaboratively with school jurisdictions to develop school nutrition policies.	• Of the 53 school jurisdictions Health Promotion Coordinators (HPCs) are assigned to support, 40 are partnering at a district-level, 21 have nutrition policies in place and 16 of these policies make reference to the Alberta Nutrition Guidelines for Children and Youth. HPCs continue to build relationships with school jurisdictions and support the development of nutrition policies.
Promote and improve equity in population health outcomes through advancing the Promoting Health Equity Framework within AHS.	• An AHS Promoting Health Equity Strategy is under development that outlines a long-term plan of action to improve the overall health of Albertans by reducing the differences in health status that are unfair, unjust and modifiable. The strategy consists of two components: the Promoting Health Equity Framework and Action Plan. • A draft AHS Health Equity policy has been developed and waiting approval to proceed. • A technical paper on pan-Canadian approaches to health equity developed in collaboration with the Public Health Agency of Canada and the National Collaborating Centre for the Determinants of Health will be presented at the World Health Organization 8th Global Conference on Health Promotion (8GCHP) in Helsinki, Finland, June 2013.
Implement an integrated food safety program to support improved and streamlined inspections.	• Launched in August 2012, the Provincial Integrated Business and IT Solution (PIBITS) has drafted a business plan, received approval and funding to proceed with architecture and planning and has outlined a value case for a province-wide solution. PIBITS works with representatives from both Alberta Health and AHS. The project anticipates releasing a Request for Proposal in late April 2013 for a province-wide solution for data gathering, storage and release as required by both AH and AHS as part of the operational deliverables and reporting for Environmental Public Health.
Develop and implement targeted strategies for addressing social determinants of health in improving access of the diverse and vulnerable populations to chronic disease prevention and management services.	• This is being addressed through the Aboriginal Health Program (e.g., development of Wisdom Council and Aboriginal Cancer/Chronic Disease Resource Manual) and through the development and implementation of the Promoting Health Equity Framework.

In Summary: In collaboration with AH, numerous initiatives have been developed, implemented and strengthened in the areas of screening programs, chronic disease prevention, injury prevention, healthy development, addiction and mental health, environmental public health and Aboriginal health/reducing disparities and communicable disease control. In addition to improving quality of life, these initiatives will help to increase life expectancy and reduce potential years of life lost.

The following results demonstrate slow, but generally steady improvement in life expectancy. More significant improvements have been shown in the reduction in potential years of life lost. While many of these initiatives take time to show their full impact, through continued focus in this area, it is anticipated that disparities in life expectancy throughout various AHS zones in the province will decrease, and that there will be an increase in life expectancy among First Nations populations.

PERFORMANCE MEASURE	2005	2007	2009	2011	2012	TARGETS
Life Expectancy: The number of years a person would be expected to live, starting at birth, on the basis of mortality statistics. Both sexes combined.						
Provincial	**80.1**	**80.6**	**81.1**	**81.9**	**82.0**	Life expectancy would increase in a manner consistent with the Canadian average, with the goal to be above the national average of 81.1 years (2007/2009 per Statistics Canada).
South Zone	79.0	80.2	80.1	81.1	80.8	
Calgary Zone	81.6	81.7	82.4	83.4	83.6	
Central Zone	78.6	79.3	80.1	80.5	80.6	
Edmonton Zone	80.3	80.8	81.0	81.9	82.4	
North Zone	77.8	78.6	79.3	79.5	80.5	
First Nations	70.6	70.6	71.1	70.9	72.4	
Non-First Nations	80.5	81.0	81.5	82.3	82.3	
Potential Years of Life Lost per 1,000 Population: The total number of years not lived by an individual who died before their 75th birthday.						
Total Population	**53.1**	**50.5**	**47.3**	**43.3**	Pending	Improvements will be seen in PYLL.
Females	38.9	38.4	37.1	33.2		
Males	67.2	62.6	57.4	53.2		

PERFORMANCE MEASURE	2008	2009	2011	2012	2015 TARGETS
Colorectal Cancer Screening Participation Rate	36.0%	43.0%	57.0%	pending	55%
PERFORMANCE MEASURE	**2008 / 2009**	**2009 / 2010**	**2010 / 2011**	**2011 / 2012**	**2015 TARGETS**
Breast Cancer Screening Participation Rate	55.9%	57.3%	54.8%	52.6%	55% - 62%
PERFORMANCE MEASURE	**2007 - 2009**	**2008 - 2010**	**2009 - 2011**	**2010 - 2012**	**2015 TARGETS**
Cervical Cancer Screening Participation Rate	70.7%	67.9%	65.0%	63.5%	70% - 75%

Sources: Colon Cancer Screening in Canada Survey by Canadian Partnership Against Cancer (CPAC); Alberta Breast Cancer Screen Program (ABCSP) and Alberta Health.

5. Promote the Provision of Health Services in a Manner that is Responsive to the Needs of Individuals and Communities, and Supports the Integration of Services and Facilities in Alberta

Build One System - Workforce

It is imperative AHS anticipate future workforce and workplace needs, and take action to attract and retain top talent. AHS must develop a workforce matched to the needs of Albertans, and enable our staff and physicians to deliver quality and safe care by providing for appropriate scope of practice, meaningful engagement and the appropriate supports such as education, an attractive and safe work environment, and efficient and effective systems and other tools.

PRIORITIES FOR ACTION: **WORKFORCE**

Efficiently utilize health professionals by matching workforce supply to demand, promoting team based delivery of services, and enabling health providers to work to the full extent of their education, skills and experience.

ACTIONS	PROGRESS/RESULTS
Enable professionals to work to the full extent of their skills and abilities, as part of larger health teams. Refresh the AHS Clinical Workforce Plan.	• Mid-year Zone Workforce Plan action plan updates were completed and implemented. • Workforce Summits were held in the Calgary, Central and Edmonton Zones. Topics included Workforce Model Transformation and Staff Scheduling Transformation projects. • Work continues with North and Central Zones to facilitate care for patients when a physician is not easily accessed, including ongoing consultation with the College and Association of Registered Nurses of Alberta (CARNA) on protocols such as management of anaphylaxis and diversion of patients from small rural sites without a physician.
Increase the available supply of health team members.	Increased Supply • There has been an 11.4% (851) increase in the proportion of full-time registered nursing positions from 7,467 to 8,318. • 2,113 positions (average 0.88 FTE) have been recruited for South Health Campus out of a planned 2,853 (74%). Increased Productivity • Provincial master rotation and relief model guidelines were developed and implemented. • Optimized rotations were implemented in 12 units at South Health Campus. • Agreement was reached with UNA to advance implementation of the optimized rotations in two sites for a total of 11 acute care units and 1 rural site. Effective Utilization of the Clinical Workforce • Workforce Model Transformation Communication commenced January 2013. Future state models have been approved and implementation planning is in progress. The changes to provider mix will occur on the demonstration units in 2013-14. A complementary Workforce Model Transformation Optimization for the Allied Health Workforce is underway. Innovating Attraction and Retention • North Zone RN Locum strategy launched in January 2013. • A total of 196 Transition Graduate Nurses (TGNs) were hired, 126 of whom should be ready for independent practice (i.e., transfer to regular positions) in the spring. Evaluation results show increased intent to stay with AHS and in nursing (91%). • 832 domestic and 13 international employees were hired through Candidate Relationship Management. This continues to function successfully, enabling continuous engagement between AHS and external candidates and it also is a successful strategy demonstrating the ability to match "right skill" with areas of need. • Various branding and marketing strategies including placing job posting ads, participating at career events and using social media (Facebook,Twitter).
Roll out workforce plan for nurse practitioners in primary care, seniors care, continuing care and cancer care.	• A revised version of the Nurse Practitioners Clinical Workforce strategy is currently being reviewed by stakeholders. • Classification and compensation review of nurse practitioners underway including redevelopment of the provincial role description to be completed June 2013.

PRIORITIES FOR ACTION: **WORKFORCE**

Efficiently utilize health professionals by matching workforce supply to demand, promoting team based delivery of services, and enabling health providers to work to the full extent of their education, skills and experience.

ACTIONS	PROGRESS/RESULTS
Continue to roll out the Midwifery workforce plan.	• Midwifery Staff Bylaws and Rules were endorsed. • The infrastructure to support midwifery services has been established. • Midwifery Services Agreement was approved in January 2013. • Negotiations are underway between AHS and two Primary Care Networks related to ongoing midwifery services. • AHS and Alberta Association of Midwives are jointly developing a midwifery services database to collect and report data related to all aspects of midwifery services.
Support evidence-informed excellence through processes, tools and education.	• A total of 44 Practice Wise sessions were held with 2,370 logins from various sites. Each site may have one or multiple persons logging in to participate. • Practice Support Tools have been collated and a Clinical Reference Paper for the 'Driving Assessment' project is complete. Various communication strategies were implemented to support the sharing of these tools across AHS. • Online learning modules and references available to all staff in support of the implementation of the approved Expressed Breast Milk and IV Line Tracing clinical policies.
Facilitate networking and information sharing strategies.	• Informal and formal networking continues to enhance information sharing regarding practice leadership and supports with HPSP and zones, post-secondary institutions, regulatory colleges, and professional associations.
Continue implementation of the Therapist Assistant role optimization.	• The Therapist Assistant Role Optimization project information sessions are complete. • All ten professional practice councils have representation from all zones.
Advance the provincial approach for orientation to specialty areas.	• Phase I (Urban and Tertiary Sites) Emergency Orientation: Ten of 14 sites have fully implemented the new program with a total of 130 RNs trained. • 480 registered nurses have completed the standardized Critical Care Orientation. A contract is secured to purchase online learning material for key elements of the education. • AHS is supporting a provincial approach for a standard operating room orientation for registered nurses. • Professional development educational sessions for rural educators have been launched; three sessions have been held.
Continue commitment to recruit at least 70 per cent of registered nurses graduated in Alberta.	• 1,836 new nurse graduates have been hired year to date, 71% to non-casual positions. • Talent Acquisition Advisors in the zones organized and attended 12 New Graduate 'Meet and Greet Events' across all five zones engaging approximately 432 students.
Develop and deliver education programs for health care providers working with vulnerable populations, individuals who have chronic diseases, addiction and mental health issues.	• Addiction and Mental Health, working within the Specialty Orientation Framework, have created 'Readiness to Practice' competency-based resource collections for interprofessional staff development. Topics include: Therapeutic Relationship Building, Knowledge of Addiction and Mental Health, Prevention and Health Promotion, Screening, Assessment, Service and Treatment Planning, Intervention and Treatment, and Evaluation. • Elopement Prevention staff training is in development, including targeted prevention, risk assessment, communication and teamwork strategies to reduce risks by strengthening an environment of strong therapeutic engagement.
Implement Just and Trusting Culture initiatives.	• Just Culture Guiding Principles approved / endorsed by AHS Executive Committee in March 2013. Just Culture principles will be integrated into existing and forthcoming AHS policies and within the context of all AHS values). • On-line decision support and education resources currently under development.

In Summary: Ensuring the AHS workforce is supported, and their skills are utilized in the most appropriate and efficient way is of utmost importance to AHS. Continued efforts have resulted in recruiting the vast majority of RN graduates. The ratio of full-time equivalent to headcount showed significant improvement and has surpassed the 2012-13 target.

PERFORMANCE MEASURE	2009 / 2010	2010 / 2011	2011 / 2012	2012 / 2013	2012 / 2013 TARGETS
Percent of Alberta university/college Registered Nurse graduates hired by AHS. *Total includes casual and non casual; non casual includes full-time and part time permanent and temporary.*	n/a	Total = 87% Non Casual = 41%	Total = >98% Non Casual = 67%	Total = >98% Non Casual = 71%	70%
Ratio of AHS staff head count to full-time equivalent (FTE)	1.57	1.57	1.55	1.52	1.61

Source: AHS Human Resources

PRIORITIES FOR ACTION: **ENGAGEMENT**

Enhance staff and physician satisfaction.

ACTIONS	PROGRESS/RESULTS
Optimize physician participation in strategic clinical networks.	• Each of the SCNs is co-lead by a Senior Medical Director (SMD). Over 80 physicians are involved in the six SCNs and approximately 50 physicians involved in the three OCNs. • Consultation with the Alberta Medical Association (AMA), Primary Care Alliance, College of Physicians & Surgeons (CPSA) and zones to ensure representation of physicians at each core committee. • OCN SMD contract finalization is expected to be complete by end of January 2013. • Opportunities for SMD participation in courses offered by the Physician Management Institute within the zones.
Implement the first phase of the AHS leadership capacity and skills development program.	• Leadership Development is partnering with Medical Affairs to draft a Physician Leadership Development program and plan that can be accessed by physicians across the province. The goal is to complete a high level needs assessment and strategy.
Implement proposed processes to optimize physician potential for advocacy.	• AHS working in partnership with the AMA and the CPSA to develop common working definitions and an advocacy framework that describes clear roles and responsibilities, and processes and core competencies for effective physician engagement. Focus groups will be identified that will provide feedback.
Develop and implement a strategy for embedding the three new values into AHS culture.	• A cultural assessment was undertaken to gain a better understanding of our AHS culture and how that culture helps support our three key goals of providing quality, access and sustainable health care. The first step was to gather an 'inventory' of culture-related initiatives occurring throughout AHS. Senior Leaders responded to this request for information by providing approximately 60 culture-related initiatives currently underway in 27 departments. This multitude of culture-related initiatives illustrated AHS' dedication to continually improving culture, a pride in the good work being done. Next steps include building a framework that identifies and supports the alignment of all cultural initiatives towards a values-based culture.
Update Engagement Action Plan to focus on initiatives in staff learning, leadership development, communications, resourcing, local autonomy and decision making.	• A communication plan was developed with objectives that include: providing a status update, recognizing and celebrating success, providing venues for idea sharing and storytelling, and providing supports to managers and teams. The plan is well underway and a variety of communications tools and tactics will be used, including additional resources for leaders and teams. Initial communications will include: Leadership Matters articles, Interchange article, toolkit for managers, and storytelling forums. • Additional communication tools will be used to sustain presence and momentum (e.g. communicating vision/ connecting the dots, Interchange articles, Coffee Talk sessions, photo galleries, Bulletin Board Network and contests).
Develop and implement specific initiatives focused on supporting front-line managers/ supervisors.	• To support front-line managers/supervisors to optimize the information obtained from the workforce engagement survey, the following resources are in place: Leaders Toolkit Webcasts, Understanding Engagement Report Webcast, Leaders Action Toolkit, Leaders Toolkit Booklet, Methodology for Survey Reports, A Quick Guide to Engagement Best Practices, Guidelines to Local Action Planning, Local Action Planning Template, Employee Appreciation, Leadership Development, Learning & Development, Performance Management, AHS Overall Survey Results Webcast, and Employee, Medical Staff, and Volunteer Results Webcasts.
Introduce changes to the performance management process to embed values, competencies.	• The new In-Scope Performance Conversation Summary form was implemented in January 2013. The revised Management & Out-of-Scope (MOOS) Performance Appraisal form was approved with implementation date of April 15. The MOOS online performance appraisal system implementation is planned for 2014.
Continue to encourage and support staff and front-line manager and physician active involvement and participation in designing teams and models of care.	• Zone and Provincial Medical Affairs provides advice/support on physician engagement strategies.

In Summary: AHS teams developed local engagement plans to further bolster engagement from the ground up. By building these plans and acting on them, we are investing in relationships that will increase our collective productivity and energy and will help us deliver on our shared goal of providing Albertans with a high quality health care system they can be proud of.

PERFORMANCE MEASURE	2009 / 2010	2011 / 2012	2012 / 2013	2012 / 2013 TARGET
Staff and Physician Engagement Percentage of Favourable				
Overall engagement score: Employees, Physicians and Volunteers	37%	53%	n/a	68%
Staff	35%	52%	58%	
Physician	26%	39%	31%	
Volunteer	79%	85%	n/a	

Source: 2013 Pulse Survey

PRIORITIES FOR ACTION: **WORKPLACE SAFETY**

ACTIONS	PROGRESS/RESULTS
Implement the AHS Occupational Injury Action Plan which includes the following: Safe Client Handling and Manual Materials Handling Programs, Modified Work Standard, Portfolio Health and Safety Improvement Plans and department level health and safety quarterly reporting.	• The three goals of the AHS Occupational Injury Action Plan are to prevent injuries, respond assertively to injuries and support sustainable return to work for injured employees. Foundational AHS resources available to leaders include the organization's commitment to a Safety "Value", the WHS Policy and Management System, the Shared Responsibility Framework, Hazard Identification and Control, Incident Investigation program, Job Demands Summary system and Modified Work Standard. • Safe Client Handling: To date, 1,244 out of 1,450 ceiling lifts have been installed and 12,008 out of 37,000 individuals have been trained in It's Your Move. The Emergency Medical Services module has been completed and training initiated in five Zones. • Safe Manual Materials Handling (Move Safe): The plan for phased-in implementation across all Zones has been approved. The evaluation is focusing on a large scale purchase of an ergonomic mopping system. Work continued to enhance meaningful safety performance reporting: injury data has been made available at the site level to facilitate targeted reduction efforts. Implementation of the beta training at the seven facilities is complete. Evaluation is under progress. 14 "champions" identified and trained. Training is currently scheduled to begin July 2013. • Worker's Compensation Board process standardization continues and has been incorporated into an enterprise-wide Attendance and Ability Initiative. • Portfolio Health and Safety Improvement Plans: Core metrics (injury rates, immunization rates and It's Your Move training rates) are being tracked via improvement plans and will be evaluated. • Health and Safety Reporting: daily, monthly and quarterly reports are in place and are reviewed regularly with operational leaders. Site and department level reporting are now in place. Trend analysis and plans for corrective actions continue.
Implement the Canadian Standards Association compliant Workplace Health and Safety Management System.	• Implementation of the Capital Management Field Level Risk Assessment was launched. • Slips, Trips and Falls Prevention Program and Transportation of Dangerous Goods Program approved. • Indoor Air Quality Program launched. • Portfolio Health and Safety Improvement Plans for 2013-14 initiated. • AHS Health and Safety Audit baseline established with the assistance of Enterprise Risk Management and Internal Audit. • Prevention of Workplace Violence initiative continued: Working Alone Level 2 Policy completed for approval.

In Summary: Occupational injury and illness reduction plans are focusing on mitigating workplace hazards and building employee resilience to cope with workplace demands. Establishing a robust management system and supporting safety culture is ongoing; and improvements in performance measures and shared responsibility for safety outcomes are gaining traction. Continued work is also required to ensure we have the right workforce to meet the needs of our health system, and that our disabling injury rate is reduced.

PERFORMANCE MEASURE	2009 CY	2010 CY	2011/ 2012 FY	2012 / 2013 FY	2012 / 2013 TARGETS
Disabling injury rate (staff injury rate) per 100 workers.	2.83	3.19	3.87	3.82	1.8

Source: AHS Human Resources
CY refers to calendar year; FY refers to fiscal year

Build One System - Supports

Alberta Health Services is committed to developing administrative support systems and procedures that enable staff and physicians to provide excellent health care services to individuals, families and communities. The delivery of quality, safe health care services depends on efficient and effective supports.

PRIORITIES FOR ACTION: INFORMATION TECHNOLOGY

Merge and standardize operating systems, use information technology and information to improve cost effectiveness of health care service delivery. Put in place consolidated systems and processes to create a sustainable operating environment for AHS systems. These range from human resources/ payroll and finance to clinical information and reference systems.

ACTIONS	PROGRESS/RESULTS

Continue to promote the implementation and use of Netcare across the province. Develop common information systems for patient care.	• Netcare usage continues to rise on a monthly basis. Additional clinical reports were made available through Netcare in December 2012 which helps to increase the overall value of Netcare to clinicians throughout Alberta:
	  • Edmonton and Rural Zones: Seniors' Health; Personal Health Profile Reports
	  • Calgary zone: Continuing Care Client Profile Reports, Event History from Calgary Medipatient facilities, Mitogen Advanced Diagnostics Lab results
	• Netcare Physician Usage continues to show overall increases over 2011.

Develop plan for an Edmonton Clinical Information System (CIS).	• The CIS project is a legal patient record created in hospitals and ambulatory environments that stores patient information electronically. CISs are not shared across the province, but provide information to the provincial Electronic Health Record system. • The Edmonton Zone CIS selection process is near completion. Software demonstrations were held at a number of facilities in Edmonton. The demonstrations provided the opportunity to give scored feedback. Additional demonstrations for AHS clinical audiences were held in winter 2013. Implementation planning and clinical engagement continues.
Health Information Management (HIM) enables permanent electronic patient record.	• The business and implementation plan for a pilot of the Permanent Electronic Patient Record (PePPR) at South Health Campus is under discussion regarding the implementation of Enterprise Content Management as a demonstration site. Funding is still being investigated.
Develop a knowledge portal available to AHS clinicians, staff and other health care providers.	• A Knowledge Portal for the SCN's and OCN's went live in early January 2013. On-boarding of users continues both internally and externally. Training webinars are underway, with many SCN/OCN managers having already completed it.
Complete Phase II of e-people roll out. Continue to refine financial system and reporting.	• The final rollout of e-People Wave 2 is on track to go live April 2013, moving the remainder of North Zone, all of the South Zone, and Edmonton EMS to the provincial platform. • Implementation of e-People for Covenant Health continues with plans to finalize timelines and financial estimates by the end of the fiscal year. Full implementation will proceed fall 2013, with a target initial rollout date in spring 2014.

In Summary: Numerous Information Technology initiatives continue to be implemented on a province-wide basis. Through consolidation of IT systems and infrastructure savings of over $13.3 million was achieved since 2010-11. Investment in technology is critical to enable a high functioning, safe, efficient health system. This will continue to be advanced in a coordinated and prioritized manner.

PERFORMANCE MEASURE	2009 / 2010	2010 / 2011	2011 / 2012	2012 / 2013	2012 / 2013 TARGETS
Alberta Netcare: Number of physician and nurse users who access the Electronic Health Record system across the continuum of care.	10,067 peak quarter	11,816 in Q4 17% increase	14,605 in Q4 24% increase	18,309 in Q4 25% increase	+10% increase from 2011-12
AHS Information Technology Strategy: Consolidate, Unify, Optimize. Move to common systems to provide standardization around common processes, tools and information.	Email system, networks and IT services consolidated and optimized	Financial systems consolidation process achieved	Completed HR/ Payroll and Financial systems consolidation	Pharmacy computerized physician order entry part of the CIS scope	Begin roll out of Pharmacy Ambulatory computerized physician order entry
AHS Information Technology Strategy: Reduction in AHS Information Technology operating budget support consolidation of systems and infrastructure.	Budget was $213 Million	Targeted savings was $10 Million	Savings achieved of $7.9 Million	Savings achieved of $5.4 Million	-5% decrease from 2010-11

PRIORITIES FOR ACTION: FISCAL EFFICIENCIES

Ensure fiscal responsibility and good stewardship of resources, reduce duplication and streamline processes to improve efficiencies.

ACTIONS	PROGRESS/RESULTS
Develop and test a priority setting and resource allocation tool that supports the alignment of funding to key organizational goals and objectives.	• The Initiative Priority Setting Guidelines for Use and toolkit was implemented by the Strategic Clinical Networks to help determine their key priorities for 2012-13. The toolkit will also be used to determine priorities for 2013-14. The tools and process have been used across AHS focusing initially with the work of the Strategic Clinical Networks, then expanding to the OCNs and responding to requests by zones, business areas and others. The subsequent approval and funding of the SCN initiatives have been aligned with the outcomes and reviews using the priority setting tools and process.

In Summary: The financial summary can be found in the Financial section of this document.

PERFORMANCE MEASURE	2011 / 2012	2012 / 2013	2012 / 2013 TARGETS
Adherence to budget. AHS will operate within the approved operating budget (revenue minus expenses).	$82 million (2011-12), which is within 1.5% of the annual budget	$106 million (2012-13), which is within 1.5% of the annual budget	Variance no greater than + or – 1.5% of the annual budget

PRIORITIES FOR ACTION: **RESEARCH AND INNOVATION**

Making decisions based on sound research and evaluation. Begin implementation of the AHS Research and Innovation Strategy.

ACTIONS	PROGRESS/RESULTS
Working with faculties of medicine via the Academic Health Network (AHN) to further develop the Alberta Health Research and Innovation Strategy.	• Scientific directors for five SCNs are now operational and processes are in place to support the activity of each research network. This includes dedicated assistant scientific directors, Data Integration, Measurement & Reporting (DIMR) and Health Technology Assessment. • AHS, Alberta Innovates - Health Solutions (AIHS) and the universities have prepared a Strategy for Patient Oriented Research (SPOR) application for the province to Canadian • Institute of Health Research (CIHR). • The AHN/SCN Resource Working Group is in its second year. Membership of the group is drawn from AHS, University of Calgary, University of Alberta, AHN and AIHS. Its focus has been the SPOR application, SCN research development, and ensuring that health research in Alberta is a result of strategic and efficient networks. • AHS is working with Alberta Health and Enterprise and Advanced Education (EAE) to develop a health innovation framework and a living lab concept for implementation of the Alberta's Health Research and Innovation Strategy for the province.
Establishing and developing the research, innovation, and collaborative role and capacity of Strategic Clinical Networks to improve uptake of research findings, service delivery and patient and population outcomes.	• The scientific directors (SDs) are 'co-leaders' of their SCNs (a 'triad' leadership model is being established). Each SD has begun work on defining strategic plans for research. • The Cancer SCN, Critical Care OCN and Emergency Medicine OCN have prioritized applicants for their respective SD positions and negotiations are underway. • The SDs are fully engaged with their respective SCN leaders and members to identify priorities for research. Each SD has identified at least one priority (see below). • A portal for industry engagement to coordinate and align innovation opportunities internally and externally to AHS has been developed and will be aligned with the Alberta's Research and Innovation Strategy, the emerging health innovation framework and living lab concept.
Identifying other partners in research in Alberta (private, public sectors and other academic institutions).	• A meeting of all provincial applicant teams for the CIHR SPOR Support for People and Patient-Oriented Research and Trials (SUPPORT) Units was held in Ottawa in January 2013. Alberta, Newfoundland and Manitoba presented comprehensive plans. The Northwest Territories and the Yukon will collaborate with Alberta on SPOR SUPPORT. The final SPOR application for Alberta was resubmitted to CIHR in March 2013. • Joint projects with public and private sector involvement to innovate the care delivery process for patients in the home or the community setting are advancing with the General Electric Virtual Care project, the locator project and the Cisco project on Telehealth.
Identifying opportunities to leverage the contribution of research partners.	• A Memorandum of Understanding (MOU) was executed between AIHS and AHS to jointly establish the Alberta Partnership for Research and Innovation in the Health System (PRIHS) Fund. Based on the MOU, AHS is working with AIHS to establish the parameters for the type of research to be supported. AIHS agreed to manage the program and the process for identifying which projects will go forward. The program has been established with an initial contribution from each organization. The partnership will support high-quality, relevant research that looks at different or better ways of providing health care to Albertans. • The Alberta Clinical Research Consortium is the first collaborative effort between clinical researchers from academic institutions, community-based physicians, and representatives from the health care system in Alberta looking at reducing the barriers and streamlining the processes for conducting clinical research. Working groups are now developing implementation plans for generated tools and templates from focus groups. • Deputy Ministers of Health, and of Enterprise and EAE issued a joint mandate letter directing AIHS to expand the goals of the Health Research Ethics Harmonization initiative. Expectations include: creation of a single research ethics board with multiple panels, research ethics approval through a "single application, single review and single approval" process, and full reciprocity. AHS and other stakeholders are developing a collaborative plan. • The Alberta Healthcare Data Repository (AHDR) Program, developed in partnership with AH, is designed to be the single access point to authoritative sources of comprehensive health information for AH/AHS stakeholders. The AHDR will facilitate efficient access to clinical and administrative data to enhance evidence-based decision making. Reporting to the Health Information Executive Committee, the AHDR will involve key leaders from both AH and AHS; a formal governance model and name finalization to be approved in Spring 2013.
Using HQCA dimensions of quality to help prioritize funding and measure research outputs in AHS, starting with funding directed toward a small number of high value investigator-driven strategic projects.	• The framework being developed with AIHS for the Alberta Partnership for Research and Innovation in the Health System is focused on using the six dimensions of quality when identifying projects of value to AHS. • The Virtual Care Management Program has a chronic disease focus and is a joint effort of General Electric and AHS. It is being developed with involvement from the Institute of Health Economics and the Ivey School of Business Health Innovation Center to develop and implement an evaluation logic model.

PRIORITIES FOR ACTION: RESEARCH AND INNOVATION

Making decisions based on sound research and evaluation. Begin implementation of the AHS Research and Innovation Strategy.

ACTIONS	PROGRESS/RESULTS
Commissioning and starting a small number of strategic research and knowledge translation projects aimed at solving a specific problem/topic of interest to AHS.	• The scientific directors identified and obtained approval on the following research projects: ◦ Cardiovascular and Stroke: A Stroke Action Plan to address the quality of and access to stroke care in rural and urban stroke centers across Alberta. ◦ Obesity, Diabetes and Nutrition: Enhancing Recovery After Surgery and the development of Insulin Pump Therapy (IPT) clinical eligibility guidelines for children, youth and adults with type 1 diabetes. ◦ Cardiovascular, Addictions and Mental Health and Obesity, Diabetes and Nutrition SCNs: Vascular Risk Reduction program, which consists of a series of projects conducted in a phased in approach. ◦ Cancer and Bone and Joint: Access to Referral and Triage (ART) to improve access to health services. ◦ Senior's Health and Addiction and Mental Health: Appropriate use of anti-psychotics project. ◦ Bone and Joint: The Fragility and Stability program in response to the burden of hip fracture care. • The Research and Privacy working group has developed an AHS Research agreement and standards. Education sessions with repository owners are underway.
Complete five additional health technology assessments in 2012-13.	• Health technology assessments are coordinated by the Health Technology Assessment & Innovation team. Currently 40 projects are in process at various stages. • Completed Projects: Corneal Cross-Linking; Portable Prothrombin Time Systems; TMJ Arthroplasty; Hysteroscopic Sterilization; Transcutaneous Bilirubinometry Program for Neonatal Jaundice; and BioMimetic Bone Augment.
Reassess current health technologies and clinical practices for safety and effectiveness: Reassess one health technology in 2012-13.	• The Knowledge Translation team is working with the SCNs on the following reassessment projects: ◦ Cardiovascular and Stroke: Cardiac diagnostic imaging ◦ Bone and Joint Health: Reducing MRIs for acute and chronic knee problems through the spine pathway ◦ Addiction and Mental Health and Seniors' Health: Antipsychotic medications in the management of behavioural and psychological symptoms of dementia.
Implement actions under Alberta's Health Research and Innovation Strategy where Alberta Health and AHS have responsibility • To foster three technology.	• Health technology innovations currently being fostered: Linac-MRI system; GE and AHS virtual care management program; Human Factors Analysis in HTA Recommendation; Location Device project - continuing care technology initiative to monitoring elopement risk patients with GPS technology (phase II starts April 1, 2013); Clean keys assessment; and Medication titration application for heart failure.

In Summary: Exciting health research is taking place in this province that is making a difference in the lives of Albertans today and changing the course of how illness and disease will be treated in the future. We are also fortunate to have unprecedented access to new technology in this province.

PERFORMANCE MEASURE	2011 / 2012	2012 / 2013	2012 / 2013 TARGETS
Number of health technology assessments	5	6	10
Number of health technology assessments	0	3 ongoing	1
Number of health technology assessments	1	6	4

Foundational/Organizational Wide

There are a number of other actions and measures that relate to the overall development and functioning of Alberta Health Services that will help us advance our goals. Although many of these foundational actions have been described in other sections of this document, there are performance measures designed to help ensure we are improving overall patient satisfaction with services, we are fulfilling our reporting obligations to the government, we are engaging our communities, and we are improving the quality of our services through accreditation mechanisms.

PRIORITIES FOR ACTION: **PATIENT SAFETY**
Improve patient safety across the continuum.

ACTIONS	PROGRESS/RESULTS
Implementation of medication reconciliation at admission and discharge/transfer in alignment with Accreditation Canada required organizational practices.	• A Provincial Medication Reconciliation (MedRec) Measurement Plan has been approved and education materials and a communication approach to support the roll-out of this plan is currently being developed in collaboration with zone representatives. The MedRec eLearning module and external MedRec website will be available in early spring 2013. • The MedRec public engagement work has produced a report from the six focus group sessions. Work continues in collaboration with HQCA on this campaign. • Zone work continues with a focus of 'MedRec on admission' for 2013. • Detailed zone project plans have been reviewed by the AHS Provincial Leadership Committee for feedback to each zone.
Prevent infections from occurring while patients are in health care facilities.	• Antibiotic resistant organism (ARO) surveillance reports, in which methicillin-resistant staphylococcus aureus (MRSA) colonization and infection are reported, are shared broadly across AHS/Covenant Health clinical programs to raise awareness of the risk to patient safety of MRSA blood stream infection (BSI). • Surgical site infection primary arthroplasty (hip and knee) surveillance reports are shared with AHS/Covenant orthopaedic surgery programs as an outcome measure for clinical quality improvement in surgery. • Clostridium difficile infection (CDI) surveillance reports are shared broadly across AHS/Covenant clinical programs to raise awareness of the risk to patient safety of CDI. • Central venous catheter BSI surveillance reports are shared broadly with clinical staff in critical care units province-wide to raise awareness of the risk to patient safety from central line insertion. • Zone and site hand hygiene improvement plans have been established and initiatives are underway or in development to support best practice in hand hygiene. • Plans are developed for the 2013 province-wide review of hand hygiene practices commencing in May 2013.
Implementation of the Just Culture program, including the development and implementation of a standardized methodology to review and learn from adverse events across the continuum.	• AHS Executive endorsed the Just Culture guiding principles and educational resource development / implementation plan in March 2013. • On-line decision support and education resources are currently under development. • These principles will be integrated into existing and future relevant polices related to Human Resource practices/processes as well as patient safety policies and guidelines. • Work continues on the development of a decision support tool (algorithm) for managers and HR staff to determine the most appropriate steps to take following an adverse event (i.e. systems review vs. individual accountability review). • The concept of Just Culture, including the principles, will be integrated within the AHS patient safety education and training curriculum for staff and physicians. • This work will align with and be in support of any future organizational culture work, including further integration with the AHS values of respect, accountability, learning, engagement, transparency, performance and safety.
Participation in the organizational review of diagnostic imaging and pathology testing in the province.	• The Diagnostic Imaging Provincial Executive Team (DIPET) and the Diagnostic Imaging (DI) Quality Assurance Committee has developed a comprehensive Quality Assurance (QA) program to be implemented within DI provincially. The goal of the program is to reduce errors, the end product being quality. The required components of the QA program have been categorized into three streams: image quality, systemic quality and report quality. • Collaboration with western provinces to share and review benchmarks for quality with respect to image quality and professional competency. These benchmarks are expected to be reviewed by May 2013. • A preliminary needs assessment is being developed jointly with Alberta Health to establish scope and costing requirements for an electronic solution to radiologist peer review and technologist image competency. An application for grant funding from Alberta Health will follow the needs assessment. • Funding from the Alberta Children's Hospital Foundation is being provided to pilot a program aimed at image quality and competency. Existing software is available that can be used to assess report/image discrepancy as well as used for teaching purposes for technologist image competency. The product is already in use at the Alberta Children's Hospital. Diagnostic Imaging is working to create a formal pilot project that will support this initiative. An overall plan is scheduled to be completed by the end of February 2013. • Policies are under development to create the framework to guide the Quality Assurance Plan. The DI Quality Assurance Committee meet regularly to review and approve policies/ procedures to support the overall QA Plan and processes that will be rolled out in 2013.

In Summary: Patient safety remained a high priority with a variety of initiatives being implemented. In particular, much work is underway to share best practices across the province and develop standardized provincial approaches. Work is underway to develop more robust performance measures to monitor and improve patient safety. One metric below indicates that more focused work is required to analyze the factors that have lead to *Albertans Reporting Unexpected Harm*, and to implement specific strategies to lower this measure. This will be a focus in the upcoming year.

PERFORMANCE MEASURE	2006	2008	2009 / 2010	2010 / 2011	2012 / 2013	2012 / 2013 TARGETS
Albertans Reporting Unexpected Harm	13%	10%	8.7%	12.2%	10.6%	9%

PERFORMANCE MEASURE	2011 / 2012	2012 / 2013				2012 / 2013 TARGETS
		Q1	Q2	Q3	Q4	
Infection Prevention and Control: MRSA infection rate: Hospital- acquired methicillin resistant staphylococcus infection rate: incidence of cases per 100,000 admissions.	0.2	0.1	0.2	0.2	0.1	0.2

Source: AHS Infection Prevention and Control, Surveillance Program

PRIORITIES FOR ACTION: PATIENT-FOCUSED SYSTEM

Deliver a patient-focused system that captures patient perspectives on the care and services they receive in order to improve health system quality and responsiveness to patient needs and to increase patient satisfaction with the care and services they receive.

ACTIONS	PROGRESS/RESULTS
Develop and implement a patient feedback strategy including, patient satisfaction, surveys and reporting, for quality improvement purposes.	• The Patient Concerns Resolution Process Policy Suite went live for all staff and practitioners in September 2012. The Patient Relations Department website was updated to reflect the addition of the Policy Suite. Education modules about what types of feedback the Patient Relations Department collects and how to direct patients or their families who wish to provide feedback were developed. The education modules provide staff with concrete tools illustrating how to enhance the relationship with the patient and how to respond to a concern.
EMS Patient Experience Survey developed and ready for implementation.	• The results from the EMS Patient Experience Survey are posted on the AHS website. Overall, the results for all questions were very positive, with 96% of respondents having agreed or strongly agreed that "overall, they were satisfied with their EMS experience." EMS will complete an analysis of the qualitative, open-ended survey question in April.

PERFORMANCE MEASURE	2010 / 2011	2011 / 2012	2012 / 2013	2012 / 2013 TARGETS
Satisfaction with health care services received: Percentage of Albertans satisfied or very satisfied with health care services personally received in Alberta within the past year. Source: HQCA Satisfaction and Experience with Health Care Services.	62% (2010)	n/a	64% (2012)	68%
Acute Care – Hospital Services: Percentage of patients rating hospital care as 8, 9, or 10 on a scale from 0-10, where 10 is the best possible rating. Source: AHS Provincial H-CAHPS (Hospital Consumer Assessment of Health care Providers and Systems Survey).	82%	84% (Apr-Dec 2011)	82% (Apr-Dec 2012)	n/a
Continuing Care: Long-Term Care Facilities. Overall **family** rating of care at nursing homes, on a scale from 0 to 10. Source: HQCA	8.1 out of 10 (2007/2008) 8.2 out of 10 (2010/2011)			
Overall **resident** rating of care at nursing homes, on a scale from 0 to 10.	8.1 (2008)			
Emergency Department Care – Past Year: Percentage satisfied or very satisfied with their or a close family member's services at an emergency department in past year. Sources: HQCA; AHS H-CAHPS.	58% (2008) 59% (2010)	Adult = 68% Ped. = 82% (Apr – Dec 2011)	Pending	n/a
Mental Health Services: Percent of Albertans who were satisfied or very satisfied with the mental health services they received. Source: Health Quality Council of Alberta. Satisfaction with Health Care Services: A Survey of Albertans 2008 and 2010.	74% (2008) 78% (2010)	92.3%	94.9%	n/a

PRIORITIES FOR ACTION: GOVERNANCE

AHS demonstrates good governance.

ACTIONS	PROGRESS/RESULTS
Continue to refine strategy cycle in conjunction with Alberta Health and develop structures and processes to support collaborative planning.	• AHS has developed a strategic planning cycle that supports a whole system approach, and aligns with AH requirements. This allows for the integration of requirements for capital and finance planning, and appropriate time allotment for other related planning, development and approval processes. Further strengthening of the plan will incorporate the following components: • Health needs assessment (with increased focus on a geographic approach) • Population health • Value assessment and prioritizing investments • Whole system planning approach
Timely submission of AHS Board-approved reporting to the Minister of Health.	• AHS has worked with AH over the past year to develop the following documents according to the prescribed format and submitted on or prior to the submission deadlines: • Quarterly performance reports • Quarterly financial reports • 2013 - 2016 Health Plan and Business Plan • Annual Report with audited financial statements in accordance with Ministry Financial Directives • These documents have been coordinated with AH to ensure alignment with AH Direction.

PRIORITIES FOR ACTION: COMMUNITY ENGAGEMENT

Effective community engagement and public consultation that supports effective planning, delivery and evaluation of health services.

ACTIONS	PROGRESS/RESULTS
Hold an Annual Health Advisory Council meeting.	• During the third year of operation, the Health Advisory Councils were more established in their communities and hosted a number of community consultations with Albertans to provide AHS with more feedback on the local perspective surrounding health care delivery in communities across the province. Councils have become better known in their communities through ongoing engagement activities and public awareness campaigns, creating greater opportunities for engagement amongst community members and organizations. Council members have used the feedback and comments from these community consultations to inform their dialogue with AHS senior leaders.
Province-wide Health Advisory Council meeting will be held in fall of each year beginning 2012-13 to correspond with reporting timelines for the Health Advisory Councils.	• The third annual Health Advisory Council province-wide meeting was held in Edmonton and provided the opportunity for council members to further engage with AHS Board members and members of AHS Executive while learning more about and providing feedback on specified program areas. In addition, council members were provided opportunities to share engagement ideas, practices and communication techniques to improve their work in communities across Alberta. • The councils continue to provide feedback to AHS to assist in planning processes and strategic development. Several AHS planning initiatives were reviewed by councils and advice was provided to support of the work. Examples include Zone Improvement Plans, Just and Trusting Culture, Community and Rural Health Planning, Emergency Medical Services, Emergency Room Experience, Medication Reconciliation Project, Health Link, Nutrition and Food Services, Physician Recruitment and Retention, and many aspects of local health care services throughout the province. • Members of the AHS Board continue to be informed about council activities and issues being addressed with operational leaders, as well as their perspectives on health care. Board members also attend council meetings throughout the province on a regular basis to become more aware of the work of councils, and to directly learn about health care services and opportunities for improvement. • The Provincial Advisory Council on Cancer was established in April 2011 and has been effective in strengthening the working relationship with AHS Cancer Care. Representing different areas across the province, the members bring their local knowledge and insight as they help identify opportunities within the community where cancer care services can be improved. As the Council continues to strengthen, it will be better informed and work more effectively in bringing advice forward regarding potential challenges, gaps, opportunities and strategic investment within the cancer services. The Council has a limited ability to engage the public directly due to its broad provincial scope; therefore, council members have chosen to extend their local knowledge of public members' views, opinions and insight to include new partnerships through linkages with the geographically-defined Health Advisory Councils. Several initiatives/projects underway within AHS Cancer Care were reviewed with members to assist them in developing future priority areas for their consideration. Members are looking forward to the anticipated announcement by government of the Alberta Cancer Plan. The goals and strategies of the plan will be critical to informing the Council's work plan. The Council also provided feedback to AHS on other initiatives this year, including the Cancer Care Strategic Clinical Network (SCN), and the Colorectal Cancer Screening Program.

PRIORITIES FOR ACTION: **COMMUNITY ENGAGEMENT**

Effective community engagement and public consultation that supports effective planning, delivery and evaluation of health services.

ACTIONS	PROGRESS/RESULTS
	• A Provincial Advisory Council on Addiction and Mental Health was established by the AHS Board in December 2011. After completing the appointment and recruitment process for its fifteen members, the Council held its inaugural meeting in June 2012. The inaugural year has been effective in setting up processes, and building foundational relationships with both the AHS Board and leadership. Continually nurturing these connections will enable the Council to be better informed and work effectively to seek and appropriately consider evidence and information from Albertans when advising on addiction and mental health planning and delivery and when evaluating addiction and mental health services. In addition to completing the Council's organizational tasks, members have served on a number of committees that relate to the Council's mandate, including the Addiction and Mental Health Strategic Clinical Network, and the recently formed Patient Engagement Reference Group. Members have identified and prioritized key issues in addiction and mental health that are of concern to them and their public. Council members have chosen to extend their local knowledge of public members' views, opinions and insight through the development of a public awareness campaign and with new partnerships. It has chosen to develop linkages with the geographically defined Health Advisory Councils, communicating with each on a regular basis and attending each other's meetings, in order to extend its ability to bring public addiction and mental health related concerns forward. The Council provided feedback to AHS on several topics this year, including the Provincial Elopement Safety Review (Electronic Health Records, Development of Consumer Tool, Improving Safety in Mental Health Units & Facilities) and the Addiction & Mental Health Network SCN.
Develop Annual Health Advisory Council Work Plans and provide to the Health Advisory Committee of the Board. Advisory Council Annual Report: 2011-12 and 2012-13 Annual Reports will be completed by each Health Advisory Council and provided to Health Advisory Committee of the Board, the AHS Board and the Minister of Health. Actively consult and engage Aboriginal and non-Aboriginal community stakeholders in chronic disease management service development and implementation for diverse and vulnerable populations.	• The following is based on highlights as published by the AHS Community Advisory Councils • Engagement Consultations to provide advice and support to AHS: • Closer to Home: Consultation with local resident councils to support changes to improve the quality of the food experience in the long-term care centres across Alberta. • Making Moments Matter: Support to front-line providers working in emergency departments and EMS to focus on making the patients experience better (Greater Edmonton HAC). • National Non Smoking Week: Disseminated awareness material on behalf of AHS. • Health Link Alberta Advisory Council: Participated in strategic and tactical planning for HLA (Yellowhead East HAC). • EMS service transition from Edmonton Municipal to International Airport (North, Edmonton and Central Zone HACs). • AHS Surgical Clinical Network: Improve access to surgery and reduce wait times (All Zones). • Medication Reconciliation: Perspectives on the public role (David Thompson HAC). • Colorectal Cancer Screening program recommendation. • PAC communication plan was created. • Chronic Disease Management: The program requested that members complete an online survey to provide input to the program name (All Zones). • A number of councils set up booths at trade shows and community fairs to meet local community members and hear from the public about health care in communities. • Zone Integration Planning: Six HAC chairs participated in a meeting with North Zone executive leads to ensure continued involvement in service planning for their respective areas. • The Tamarack HAC chair attended a presentation by Environmental Health on water safety. • A member of the Tamarack HAC attended a presentation on HIV/AIDS by the Tree of Creation Society in the community of Marlboro. • Prairie Mountain HAC hosted a community engagement event in Calgary focused on seniors' health to hear from interested members of the public. • Numerous councils sent representatives to the Rural Alberta Community Physician Attraction and Retention conference in Edmonton in October. • Members from David Thompson HAC attended a community connection event in Drumheller. • Peace HAC has been invited to the Northern Alberta Elected Leaders Meeting in Grande Prairie. Peace will make a presentation on the role and achievements of the North Zone HACs.

PRIORITIES FOR ACTION: **ACCREDITATION**

AHS undertakes accreditation activities in compliance with the Minister's directive on mandatory accreditation.

ACTIONS	PROGRESS/RESULTS
Participation in Accreditation Canada's QMENTUM program.	• Action plans to address required follow-up from the October 2012 Accreditation Canada on-site survey have been developed for each applicable site, while maintaining a zone perspective on common follow-up requirements (e.g., Central Zone Standardized Falls Risk Management Strategy is currently being developed for all Central Zone sites, Edmonton Zone Addiction and Mental Health Falls Prevention Strategy currently being implemented at all Addiction and Mental Health facilities in the Edmonton Zone). • Bi-monthly progress and risks are being reported to the Provincial Accreditation Oversight Leadership Committee (PAOLC). • PAOLC inaugural meeting was held January 2013. This committee will serve as a collaborative structure accountable for providing coordination and direction of approach and implementation of accreditation within AHS. • Site selection for the May 2014 Accreditation Canada on-site survey has begun. A completed list of participating sites is anticipated for May 2013. • Service Excellence Teams for standards to be assessed in 2014 are identifying priorities.
Participation in the College of Physicians and Surgeons of Alberta accreditation programs.	• The College of Physicians and Surgeons of Alberta reviewed the results of the HQCA Anatomic Pathology Review with Laboratory Services and Contracting, Procurement & Supply Management. • Work plans will address the recommendations of the Health Quality Council of Alberta Report to AHS - Rockyview General Hospital and Calgary Laboratory Services Diagnostic and Scientific Centre and Royal Alexandra Hospital: Review of the Quality of Anatomical Pathology Specimen Preparation and Interpretation 2010–11. AHS is assessing the feasibility of implementing a fully independent accreditation process for medical diagnostic laboratories.
Contracted services participating in appropriate accreditation program.	• AHS continues to work with Alberta Health to review, revise and enhance Ministerial Directive D5-2008 (Mandatory Accreditation in Alberta's Health System) to further clarify its application and to develop criteria and a process to approve new accrediting organizations suitable for Alberta's health system.
AHS developing a database to track accreditation activities for contracted services.	• Emergency Medical Services, Seniors Health and Addictions & Mental Health programs are standardizing their lists of contracted service providers, including accreditation status.

Health Quality Council of Alberta

We continue to welcome the opportunity to work in partnership with the Health Quality Council as we work to become the best-performing, publicly funded health system in Canada. The Health Quality Council of Alberta's mandate to promote and improve patient safety and health service quality on a province-wide basis plays an important part in Alberta Health Services working towards achieving its mission to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans. The reviews the Health Quality Council of Alberta has conducted on AHS programs and services has been integral towards achieving our goal of a high quality health system. The Health Quality Council of Alberta has provided recommendations as part of the following reviews completed in 2012/13:

- Review of the Operations of Emergency Medical Services (EMS) in Alberta
- Rockyview General Hospital, Calgary Laboratory Services Diagnostic and Scientific Center and the Royal Alexandra Hospital Review of the Quality of Anatomical Pathology Specimen Preparation and Interpretation 2010-2011 – November 2012

AHS continues to implement the recommendations provided by the Health Quality Council of Alberta reviews completed prior to the 2012/13:

- Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy – February 2012
- Review of the Safety Implications for Patients Requiring Medevac Services to and from the Edmonton International Airport – May 2011
- Review of Alberta Response to the 2009 H1N1 Influenza Pandemic – December 2010
- Quality Assurance Review of the Three Medication and One Expressed Breast Milk Incidents at the Alberta Children's Hospital, Calgary Alberta – March 2010
- Review of Infection Prevention and Control in the High Prairie Health Complex (focusing on the re-use of the single-use syringes) – July 2009
- Leading Practices Related to the Administration of Medications, Including Chemotherapy Medication, through IV Pumps in Ambulatory Care Settings – May 2007

Alongside work on the Health Quality Council of Alberta's recommendations, AHS is working to implement recommendations put forward from the external review requested by the Minister of Health:

- A Review of Alberta Health Services: Physician Credentialing & Practice Privileging for Pathology & Radiology – November 2012

Surgical Contracts

Non-Hospital Surgical Facility Contracts under the Health Care Protection Act (Alberta)

Alberta Health Services contracts with multiple Non-Hospital Surgical Facilities (NHSF) to provide insured surgical services for dermatology, ophthalmology, oral maxillofacial, otolaryngology, plastic surgery and pregnancy terminations. The use of NHSFs enables AHS to obtain quality services to enhance surgical access and alleviate capacity pressures within AHS main operating rooms.

AHS determines if the contract is appropriate by assessing sustainability of the public system, access to services, patient safety, appropriateness, effectiveness, cost and public benefit. Contracts with NHSFs provide increased choice of service provider for patients and supplement the resources available in hospitals, while providing good value for public dollars.

The following table summarizes the contracts by service area for 2012-13.

SERVICE AREA	NUMBER OF OPERATORS	NUMBER OF PROCEDURES PERFORMED
Dermatology *(Only in Edmonton Zone)*	1	30
Ophthalmology	12	21,172
Oral and Maxillofacial Surgery	18	2,961
Otolaryngology (ENT) *(Only in Edmonton Zone)*	1	67
Plastic Surgery *(Only in Edmonton Zone)*	2	605
Pregnancy Termination	2	10,936

Surgical contracts with NHSFs are in the Calgary and Edmonton Zones; there are no surgical contracts with NHSFs in the South, Central or North Zones.

List of AHS Funded Facilities

Legend:

FACILITY TYPE ABBREVIATION	DESCRIPTION	EXPLANATION
Addiction	Addiction Treatment Beds/Spaces	Facilities with beds and mats for clients with substance use and gambling problems. Includes detoxification, nursing care, assessment, counseling and treatment. Direct services provided by AHS as well as funded and contracted services. Also includes beds for PChAD (Protection of Children Abusing Drugs) program clients and residential beds funded through the Safe Communities Initiative.
Comm MH	Community Mental Health Beds/Spaces	Mental health support home programs, Canadian Mental Health Association community beds and other mental health community beds/spaces.
Psych	Stand-alone Psychiatric Facilities	Stand-alone psychiatric facilities: 1. Alberta Hospital Edmonton (Edmonton) 2. Centennial Centre for Mental Health and Brain Injury (CCMHBI) (Ponoka) 3. Claresholm Centre for Mental Health and Addictions (Claresholm) 4. Southern Alberta Forensic Psychiatric Centre (Calgary) 5. Villa Caritas (Edmonton)
Hospital (Acute Care)	Hospital	Acute Care Hospitals where active treatment is provided. ED reflects facilities with Emergency Departments and no acute care beds. CA reflects Cancer Care facilities. OP reflects facilities providing ambulatory services.
Hospital (Subacute)	Subacute in an Auxiliary Hospital	Subacute care provided in Auxiliary Hospital for the purpose of receiving convalescent and/or rehabilitation services, where it is anticipated that they will achieve their functional potential, to enable them to improve their health status and to successfully return to the community.
LTC (AUX,NH)	Long Term Care	Long term care is provided in nursing homes and auxiliary hospitals. It is reserved for those with unpredictable and complex health needs, usually multiple chronic and/or unstable medical conditions. Long-term care includes health and personal care services, such as 24-hour nursing care provided by registered nurses or licensed practical nurses.
Palliative	Palliative	Facilities where a designated program or bed for the purpose of receiving palliative care services including end of life and symptom alleviation not in an acute care facility. Include community hospice beds.
SL	Supportive Living	Supportive living include comprehensive services such as the availability of 24-hour nursing care (levels 3 or 4). Supportive Living 4-Dementia (SL4D) is also available for those individuals living with moderate to severe dementia or cognitive impairment. Albertans accessing supportive living services generally reside in lodges, retirement communities, or supportive living centres.
Cancer Centre	Cancer Care	Cancer Care Services include: Assessments and examinations, supportive care, pain management, prescription of cancer-related medications, education, resource and support counseling and referrals to other cancer centres.
CACC	Community Ambulatory Care Centre	A community ambulatory care centre (CACC) is a community-based service delivery site (non-hospital setting) primarily engaged in the provision of ambulatory care diagnostic and treatment services. This includes typically scheduled primary care for clients who do not require hospital outpatient emergency care or inpatient treatment.
CACC (UCC, AACC)	Urgent Care Centre/ Advanced Ambulatory Care Centre	Urgent Care Centre (UCC) and Advanced Ambulatory Care Centres (AACC) provide assessment, diagnostic and treatment services for unscheduled patients who require immediate medical attention for injuries/illness that require human and technical resources more intensive than what is available in physicians office.

South Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital (Acute Care)	Hospital (Subacute)	LTC (AUX, NH)	Palliative	SL	Cancer Centre	CACC	CACC (UCC, AACC)
Bassano Health Centre	X	Bassano				X		X					
Crowsnest Pass Health Centre	X	Blairmore				X		X					
York Creek Lodge		Blairmore								X			
Bow Island Health Centre	X	Bow Island				X		X					
Pleasant View Lodge		Bow Island								X			
Brooks Health Centre	X	Brooks				X		X					
Orchard Manor		Brooks								X			
Sunrise Gardens		Brooks								X			
Cardston Health Centre	X	Cardston				X		X					
Chinook Lodge		Cardston								X			
Good Samaritan Lee Crest		Cardston								X			
Coaldale Health Centre	X	Coaldale				OP		X					
Sunny South Lodge		Coaldale								X			
Extendicare Fort MacLeod		Fort MacLeod						X					
Foothills Detox Centre		Fort MacLeod	X										
Fort MacLeod Health Centre	X	Fort MacLeod				ED							
MacLeod Pioneer Lodge		Fort MacLeod								X			
Chinook Regional Hospital	X	Lethbridge				X							
Jack Ady Cancer Centre	X	Lethbridge	Co-located on same campus as Chinook Regional Hospital								X		
Columbia Assisted Living		Lethbridge								X			
Edith Cavell Care Centre		Lethbridge						X					
Extendicare Fairmont Park		Lethbridge								X			
Golden Acres Lodge		Lethbridge								X			
Good Samaritan Park Meadows Village		Lethbridge								X			
Good Samaritan West Highlands		Lethbridge								X			
Legacy Lodge		Lethbridge								X			
South Country Treatment Centre		Lethbridge	X										
Southern Alcare Manor		Lethbridge	X										
St Michael's Health Centre		Lethbridge					X	X	X				
St. Therese Villa		Lethbridge								X			
Youth Residential Services	X	Lethbridge	X										
Good Samaritan Garden Vista		Magrath								X			
Magrath Health Centre		Magrath										X	
Club Sierra		Medicine Hat						X		X			

South Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital (Acute Care)	Hospital (Subacute)	LTC (AUX, NH)	Palliative	SL	Cancer Centre	CACC	CACC (UCC, AACC)
Cypress View		Medicine Hat								X			
Good Samaritan South Ridge Village		Medicine Hat						X		X			
Leisure Way		Medicine Hat								X	X		
Meadow Lands		Medicine Hat								X			
Medicine Hat Regional Hospital	X	Medicine Hat				X							
Margery E. Yuill Cancer Centre	X	Medicine Hat	Co-located on same campus as Medicine Hat Regional Hospital								X		
Riverview Care Centre		Medicine Hat						X					
St. Joseph's Home		Medicine Hat	Co-located Palliative beds are known as Carmel Hospice					X	X	X			
Sunnyside Care Centre (South Country Village)		Medicine Hat						X					
Haven of Rest (South Country Village)		Medicine Hat								X			
The Wellington Retirement Residence		Medicine Hat								X			
Valleyview		Medicine Hat						X		X			
Milk River Health Centre	X	Milk River				ED		X					
Prairie Rose Lodge		Milk River								X			
Big Country Hospital	X	Oyen				X		X					
Piyami Health Centre		Picture Butte										X	
Piyami Lodge		Picture Butte								X			
Piyami Place		Picture Butte								X			
Good Samaritan Vista Village		Pincher Creek								X			
Pincher Creek Health Centre	X	Pincher Creek				X		X					
Good Samaritan Prairie Ridge		Raymond								X			
Raymond Health Centre	X	Raymond				X		X					
Clearview Lodge		Taber								X			
Good Samaritan Linden View		Taber								X			
Taber Health Centre	X	Taber				X		X					

Calgary Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital (Acute Care)	Hospital (Subacute)	LTC (AUX, NH)	Palliative	SL	Cancer Centre	CACC	CACC (UCC, AACC)
Airdrie Regional Health Centre	X	Airdrie											X
Bethany Airdrie		Airdrie						X					
Mineral Springs Hospital		Banff				X		X					
Oilfields General Hospital	X	Black Diamond				X		X					
Agape Hospice		Calgary							X				
Alberta Children's Hospital	X	Calgary				X							
Alpha House		Calgary	X										
Approved Homes - Mental Health		Calgary		X									
Aspen Family and Community Network		Calgary	X	X									
Aventa Addiction Treatment for Women		Calgary	X										
Bethany Calgary		Calgary						X					
Bethany Harvest Hills		Calgary						X					
Beverly Centre Glenmore		Calgary						X					
Beverly Centre Lake Midnapore		Calgary						X					
Bow Crest Care Centre		Calgary						X					
Bow View Manor		Calgary						X					
Calgary Community Rehabilitation Program		Calgary		X									
Canadian Mental Health Association		Calgary		X									
Canadian Mental Health Association (Hamilton House)		Calgary		X									
Canadian Mental Health Association (Robert's House)		Calgary		X									
Carewest Colonel Belcher	X	Calgary						X		X			
Carewest Dr. Vernon Fanning	X	Calgary					X	X					
Carewest Garrison Green	X	Calgary						X					
Carewest George Boyack	X	Calgary						X					
Carewest Glenmore Park	X	Calgary					X						
Carewest Nickle House	X	Calgary								X			
Carewest Rouleau Manor	X	Calgary						X					
Carewest Royal Park	X	Calgary						X					
Carewest Sarcee	X	Calgary				X	X	X	X				
Carewest Signal Pointe	X	Calgary						X					
Centre of Hope - Salvation Army		Calgary	X										
Clifton Manor		Calgary						X					

Calgary Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital (Acute Care)	Hospital (Subacute)	LTC (AUX, NH)	Palliative	SL	Cancer Centre	CACC	CACC (UCC, AACC)
Community Living Alternatives for the Mentally Disabled Association (Community LAMDA)		Calgary		X									
Eau Claire Retirement Residence		Calgary								X			
Edgemont Retirement Residence		Calgary								X			
Enviros Wilderness School Association		Calgary	X										
Extendicare Cedars Villa		Calgary						X					
Extendicare Hillcrest		Calgary						X					
Father Lacombe Care Centre		Calgary						X					
Foothills Medical Centre	X	Calgary				X							
Fresh Start Recovery Centre		Calgary	X										
Glamorgan Care Centre		Calgary						X					
Hull Homes Detox/PChaD		Calgary	X										
Intercare at Millrise		Calgary						X					
Intercare Brentwood Care Centre		Calgary						X					
Intercare Chinook Care Centre		Calgary						X	X				
Intercare Southwood Care Centre		Calgary						X	X				
Mayfair Care Centre		Calgary						X					
McKenzie Towne Care Centre		Calgary						X					
McKenzie Towne Retirement Residence		Calgary								X			
Millrise Place		Calgary								X			
Monterey Place		Calgary								X			
Mount Royal Care Centre		Calgary						X					
Newport Harbour Care Centre		Calgary						X					
Oxford House		Calgary	X										
Personal Care Homes - Continuing Care		Calgary								X			
Peter Lougheed Centre	X	Calgary				X							
Prince of Peace Harbour		Calgary								X			
Prince of Peace Manor		Calgary								X			
Recovery Acres		Calgary	X										
Renfrew Recovery Centre	X	Calgary	X										
Richmond Road Diagnostic & Treatment Centre	X	Calgary				OP							
Rocky Ridge Retirement Community		Calgary								X			
Rockyview General Hospital	X	Calgary				X							

Calgary Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital (Acute Care)	Hospital (Subacute)	LTC (AUX, NH)	Palliative	SL	Cancer Centre	CACC	CACC (UCC, AACC)
Rosedale Hospice		Calgary							X				
Rotary Flames House	X	Calgary							X				
Scenic Acres Retirement Residence		Calgary								X			
SCOPE Hunterview House		Calgary		X									
Sheldon M. Chumir Health Centre	X	Calgary											X
South Calgary Health Centre	X	Calgary											X
South Health Campus	X	Calgary				X							
Southern Alberta Foresenic Psychiatric Centre	X	Calgary			X								
Sunridge Medical Gallery	X	Calgary										X	
Sunrise Native Addiction Services Society		Calgary	X										
Tom Baker Cancer Centre	X	Calgary									X		
Walden Supportive Living Community		Calgary								X			
Wentworth Manor/The Residence and The Court		Calgary						X		X			
Whitehorn Village		Calgary								X			
Wing Kei Care Centre		Calgary						X					
Woods Homes ENP (Exceptional Needs Program)		Calgary		X									
Youth Detoxification and Residential Services		Calgary	X										
Youville Women's Residence		Calgary	X										
Canmore General Hospital	X	Canmore				X		X					
Bow Valley Community Cancer Centre	X	Canmore	Co-located on same campus as Canmore General Hospital								X		
Claresholm Centre for Mental Health and Addictions	X	Claresholm			X								
Claresholm General Hospital	X	Claresholm				X							
Lander Treatment Centre	X	Claresholm	X										
Willow Creek Continuing Care Centre	X	Claresholm						X					
Bethany Cochrane		Cochrane						X					
Cochrane Community Health Centre	X	Cochrane											X
Aspen Ridge Lodge		Didsbury								X			
Didsbury District Health Services	X	Didsbury				X		X					
High River General Hospital	X	High River				X		X					
High River Community Cancer Centre	X	High River	Co-located on same campus as High River General Hospital								X		
Silver Willow Lodge		Nanton								X			

Calgary Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital (Acute Care)	Hospital (Subacute)	LTC (AUX, NH)	Palliative	SL	Cancer Centre	CACC	CACC (UCC, AACC)
Foothills Country Hospice		Okotoks							X				
Okotoks Health and Wellness Centre	X	Okotoks											X
Revera Heartland		Okotoks								X			
Strafford Foundation Tudor Manor		Okotoks								X			
Sagewood Supportive Living		Strathmore								X			
Strathmore District Health Services	X	Strathmore				X		X					
Extendicare Vulcan		Vulcan						X					
Vulcan Community Health Centre	X	Vulcan				X		X					

Central Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital (Acute Care)	Hospital (Subacute)	LTC (AUX, NH)	Palliative	SL	Cancer Centre	CACC	CACC (UCC, AACC)
Bashaw Care Centre	X	Bashaw					X	X				X	
Bentley Care Centre	X	Bentley						X					
Slim Thorpe Recovery Centre		Blackfoot	X										
Breton Health Centre	X	Breton						X	X				
Bethany Meadows		Camrose						X		X			
Faith House		Camrose								X			
Louise Jensen Care Centre		Camrose						X					
Memory Lane		Camrose								X			
Rosehaven Care Centre		Camrose						X					
St Mary's Hospital		Camrose				X					X		
Sunrise Village Camrose		Camrose								X			
Viewpoint		Camrose								X			
Our Lady of the Rosary Hospital		Castor				X		X					
Consort Hospital and Care Centre	X	Consort				X		X					
Coronation Hospital and Care Centre	X	Coronation				X		X		X			
Daysland Health Centre	X	Daysland				X							
Providence Place		Daysland								X			
Drayton Valley Hospital and Care Centre	X	Drayton Valley				X		X					
Drayton Valley Community Cancer Centre	X	Drayton Valley	Co-located on same campus as Drayton Valley Hospital								X		
Serenity House	X	Drayton Valley								X			
Sunrise Village Drayton Valley		Drayton Valley								X			
Drumheller Health Centre	X	Drumheller				X		X					
Drumheller Community Cancer Centre	X	Drumheller	Co-located on same campus as Drumheller Health Centre								X		
Grace House		Drumheller	X										
Hillview Lodge		Drumheller								X			
Eckville Manor House		Eckville								X			
Galahad Care Centre	X	Galahad						X					
Hanna Health Centre	X	Hanna				X		X					
Hardisty Health Centre	X	Hardisty				X		X					
Innisfail Health Centre	X	Innisfail				X		X					
Sunset Manor		Innisfail								X			
Islay Assisted Living	X	Islay								X			
Killam Health Care Centre		Killam				X		X					

Central Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital (Acute Care)	Hospital (Subacute)	LTC (AUX, NH)	Palliative	SL	Cancer Centre	CACC	CACC (UCC, AACC)
Good Samaritan Manor at Royal Oak		Lacombe								X			
Lacombe Hospital and Care Centre	X	Lacombe				X	X	X					
Lamont Health Care Centre		Lamont				X		X					
Linden Nursing Home		Linden						X					
Points West Living Lloydminster		Lloydminister								X			
Dr Cooke Extended Care Centre		Lloydminster						X					
Slim Thorpe Recovery Centre		Lloydminster	X										
Lloydminster Hospital		Lloydminster (Sask)				X					X		
Mannville Care Centre	X	Mannville						X					
Mary Immaculate Hospital		Mundare						X					
Eagle View Lodge		Myrnam								X			
Enviros Wilderness School (Shunda Creek)		Nordegg	X										
Olds Hospital and Care Centre	X	Olds				X		X					
Sunrise Village Olds		Olds								X			
Centennial Centre for Mental Health and Brain Injury	X	Ponoka			X								
Northcott Care Centre (Ponoka)		Ponoka						X					
Ponoka Hospital and Care Centre	X	Ponoka				X		X					
Sunrise Village Ponoka		Ponoka								X			
Provost Health Centre	X	Provost				X		X		X			
Addiction Counselling & Prevention Services	X	Red Deer	X										
Bethany CollegeSide (Red Deer)		Red Deer						X					
Extendicare Michener Hill		Red Deer						X		X			
Kentwood Place	X	Red Deer		X									
Pines Lodge		Red Deer								X			
Red Deer Hospice		Red Deer							X				
Red Deer Regional Hospital Centre	X	Red Deer				X							
Central Alberta Cancer Centre	X	Red Deer	Co-located on same campus as Red Deer Regional Hospital Centre								X		
Safe Harbour Society		Red Deer	X										
Symphony Seniors Living at Aspen Ridge		Red Deer								X			
West Park Lodge		Red Deer								X			
Rimbey Hospital and Care Centre	X	Rimbey				X		X					

Central Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital (Acute Care)	Hospital (Subacute)	LTC (AUX, NH)	Palliative	SL	Cancer Centre	CACC	CACC (UCC, AACC)
Clearwater Centre		Rocky Mountain House						X		X			
Rocky Mountain House Health Centre	X	Rocky Mountain House				X							
Stettler Hospital and Care Centre	X	Stettler				X		X					
Sundre Hospital and Care Centre	X	Sundre				X		X					
Bethany Sylvan Lake		Sylvan Lake						X		X			
Sylvan Lake Community Health Centre	X	Sylvan Lake										X	
Chateau Three Hills		Three Hills								X			
Three Hills Health Centre	X	Three Hills				X		X					
Tofield Health Centre	X	Tofield				X		X					
St. Mary's Health Care Centre		Trochu						X					
Two Hills Health Centre	X	Two Hills				X	X	X	Subacute is the Sage - Stroke & Geriatric Rehab Program				
Heritage House		Vegreville								X			
Points West Living Century Park		Vegreville								X			
St Joseph's General Hospital		Vegreville				X							
Vegreville Care Centre	X	Vegreville						X					
Vegreville Manor		Vegreville								X			
Vermilion Health Centre	X	Vermilion				X		X					
Vermilion Valley Lodge		Vermilion								X			
Extendicare Viking		Viking						X					
Viking Health Centre	X	Viking				X							
Points West Living Wainwright		Wainwright								X			
Wainwright Health Centre	X	Wainwright				X		X					
Good Samaritan Good Shepherd Lutheran Home		Wetaskiwin								X			
Sunrise Village Wetaskiwin		Wetaskiwin								X			
Wetaskiwin Hospital and Care Centre	X	Wetaskiwin				X		X					
Wetaskiwin Meadows		Wetaskiwin								X			
Wetaskiwin Serenity House (Bosco)		Wetaskiwin		X									

Edmonton Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital (Acute Care)	Hospital (Subacute)	LTC (AUX, NH)	Palliative	SL	Cancer Centre	CACC	CACC (UCC, AACC)
Kipohtakawmik Elders Lodge		Alexander Reserve								X			
Place Beausejour		Beaumont								X			
Devon General Hospital	X	Devon				X		X					
Addiction Recovery Centre	X	Edmonton	X										
Alberta Hospital Edmonton	X	Edmonton			X								
Allen Gray Continuing Care Centre		Edmonton						X					
Allendale House		Edmonton		X									
Anderson Hall	X	Edmonton		X									
Balwin Villa (Excel Society)		Edmonton								X			
CapitalCare Dickinsfield	X	Edmonton						X					
CapitalCare Dickinsfield Duplexes	X	Edmonton								X			
CapitalCare Grandview	X	Edmonton					X	X					
CapitalCare Kipnes Centre for Veterans	X	Edmonton						X					
CapitalCare Laurier House/Lynnwood	X	Edmonton								X			
CapitalCare Lynnwood	X	Edmonton						X					
CapitalCare McConnell Place North	X	Edmonton								X			
CapitalCare McConnell Place West	X	Edmonton								X			
CapitalCare Norwood	X	Edmonton					X	X	X				
CASA House		Edmonton		X									
Churchill Retirement Community		Edmonton								X			
Cross Cancer Institute	X	Edmonton									X		
Devonshire Care Centre		Edmonton						X					
Devonshire Manor		Edmonton								X			
E4C McAuley Apartments		Edmonton		X									
E4C Meadows Lodge		Edmonton		X									
E4C Our Place		Edmonton		X									
Edmonton Chinatown Care Centre		Edmonton						X		X			
Edmonton General Continuing Care Centre		Edmonton					X	X	X				
Edmonton People In Need #4 - Batoma House		Edmonton								X			
Emmanuel Home		Edmonton								X			
Extendicare Eaux Claires		Edmonton						X					
Extendicare Holyrood		Edmonton						X					

Edmonton Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital (Acute Care)	Hospital (Subacute)	LTC (AUX, NH)	Palliative	SL	Cancer Centre	CACC	CACC (UCC, AACC)
Garneau Hall		Edmonton								X			
George Spady Centre Society		Edmonton	X										
Glastonbury Village		Edmonton								X			
Glenrose Rehabilitation Hospital	X	Edmonton				X							
Good Samaritan Dr. Gerald Zetter Care Centre		Edmonton					X	X					
Good Samaritan Millwoods Care Centre		Edmonton						X					
Good Samaritan Southgate Care Centre		Edmonton						X					
Good Samaritan Wedman House		Edmonton								X			
Grand Manor		Edmonton								X			
Grey Nuns Community Hospital		Edmonton				X							
Hardisty Care Centre		Edmonton						X					
Health First Strathcona	X	Edmonton											X
Henwood Treatment Centre	X	Edmonton	X										
House Next Door #1, 2, 3		Edmonton		X									
Innovative Housing - 114 Gravelle		Edmonton								X			
Innovative Housing - Villa Marguerite		Edmonton								X			
Jasper Place Continuing Care Centre		Edmonton						X					
Jellinek House		Edmonton	X										
Jubilee Lodge Nursing Home		Edmonton						X					
Laurel Heights		Edmonton								X			
Lifestyle Options Riverbend		Edmonton								X			
Lifestyle Options Terra Losa		Edmonton								X			
Lifestyle Options Whitemud		Edmonton								X			
McDougall House		Edmonton	X										
Miller Crossing Care Centre		Edmonton						X					
Misericordia Community Hospital		Edmonton				X							
Northeast Community Health Centre	X	Edmonton				ED							
Ottewell Lodge		Edmonton		X									
Our House		Edmonton	X										
Recovery Acres Edmonton		Edmonton	X										
Riverbend Retirement Residence		Edmonton								X			
Rosedale at Griesbach		Edmonton								X			

Edmonton Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital (Acute Care)	Hospital (Subacute)	LTC (AUX, NH)	Palliative	SL	Cancer Centre	CACC	CACC (UCC, AACC)
Rosedale Estates		Edmonton								X			
Royal Alexandra Hospital	X	Edmonton				X							
Rutherford Heights Retirement Residence		Edmonton								X			
Saint Thomas Assisted Living Centre		Edmonton								X			
Salvation Army Grace Manor		Edmonton								X			
Salvation Army Stepping Stone Supportive Residence		Edmonton								X			
Shepherd's Care Ashbourne		Edmonton								X			
Shepherd's Care Greenfield		Edmonton								X			
Shepherd's Care Kensington		Edmonton						X		X			
Shepherd's Care Millwoods		Edmonton						X					
Shepherd's Care Vanguard		Edmonton								X			
Shepherd's Gardens		Edmonton								X			
South Terrace Continuing Care Centre		Edmonton						X					
St. Joseph's Auxiliary Hospital		Edmonton					X	X	X				
St. Michael's Long Term Care Centre		Edmonton					X	X					
Stollery Children's Hospital	X	Edmonton				X							
The Waterford of Summerlea		Edmonton								X			
Touchmark at Wedgewood		Edmonton						X					
Tuoi Hac - Golden Age Manor		Edmonton								X			
University of Alberta Hospital	X	Edmonton				X							
Venta Care Centre		Edmonton						X					
Villa Caritas		Edmonton			X								
Wild Rose Cottage		Edmonton								X			
Youth Stabilization and Residential Services	X	Edmonton	X										
Good Samaritan Society Pembina Village		Evansburg						X					
Fort Saskatchewan Health Centre	X	Fort Saskatchewan				X							
Rivercrest Care Centre		Fort Saskatchewan						X					
Extendicare Leduc		Leduc						X					
Leduc Community Hospital	X	Leduc				X	X						
Lifestyle Options Leduc		Leduc								X			
Salem Manor Nursing Home		Leduc						X					
Aspen House	X	Morinville								X			

Edmonton Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital (Acute Care)	Hospital (Subacute)	LTC (AUX, NH)	Palliative	SL	Cancer Centre	CACC	CACC (UCC, AACC)
CapitalCare Strathcona	X	Sherwood Park						X		X			
Country Cottage Seniors Residence		Sherwood Park								X			
Sherwood Park Care Centre		Sherwood Park						X					
Summerwood Village Retirement Residence		Sherwood Park								X			
Copper Sky Lodge		Spruce Grove								X			
Good Samaritan Spruce Grove Centre		Spruce Grove								X			
Citadel Care Centre		St. Albert						X					
Citadel Mews West		St. Albert								X			
Poundmaker's Lodge Treatment Center - Youth Addiction (Safe-Com)		St. Albert	X										
Rosedale St Albert		St. Albert								X			
Sturgeon Community Hospital	X	St. Albert				X							
Youville Auxiliary Hospital (Grey Nuns) of St. Albert		St. Albert						X	X				
Good Samaritan George Hennig Place		Stony Plain								X			
Good Samaritan Stony Plain Care Centre		Stony Plain						X		X			
WestView Health Centre - Stony Plain Care Centre	X	Stony Plain				X		X					
Family Care Homes		Various								X			
Mental Health Care Homes (Continuing Care)		Various		X									
Personal Care Homes		Various								X			
Special Care Homes		Various								X			
West Country Hearth		Villeneuve								X			

North Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital (Acute Care)	Hospital (Subacute)	LTC (AUX, NH)	Palliative	SL	Cancer Centre	CACC	CACC (UCC, AACC)
Athabasca Healthcare Centre	X	Athabasca				X		X					
Extendicare Athabasca		Athabasca						X					
Barrhead Healthcare Centre	X	Barrhead				X							
Barrhead Community Cancer Centre	X	Barrhead	Co-located on same campus as Barrhead Healthcare Centre								X		
Dr. W.R. Keir - Barrhead Continuing Care Centre	X	Barrhead						X					
Mental Health Spaces		Barrhead		X									
Shepherd's Care Barrhead		Barrhead								X			
Beaverlodge Municipal Hospital	X	Beaverlodge				X							
Bonnyville Healthcare Centre		Bonnyville				X		X					
Bonnyville Community Cancer Centre	X	Bonnyville	Co-located on same campus as Bonnyville Healthcare Centre								X		
Bonnyville Indian Metis Rehabilitation Centre		Bonnyville	X										
Extendicare Bonnyville		Bonnyville						X					
Boyle Healthcare Centre	X	Boyle				X							
Cold Lake Healthcare Centre	X	Cold Lake				X		X					
Points West Living Cold Lake		Cold Lake								X			
Ridgevalley Seniors Home		Crooked Creek								X			
Wabasca/Desmarais Healthcare Centre	X	Desmarais				X							
Edson Healthcare Centre	X	Edson				X		X					
Parkland Lodge		Edson								X			
Elk Point Healthcare Centre	X	Elk Point				X		X					
Fairview Health Complex	X	Fairview				X		X	X				
Northern Lights Regional Health Centre	X	Fort McMurray				X		X			X		
Pastew Place Detox Centre		Fort McMurray	X										
St. Theresa General Hospital	X	Fort Vermilion				X		X					
Fox Creek Healthcare Centre	X	Fox Creek				X							
Grande Cache Community Health Complex	X	Grande Cache				X		X					
Whispering Pines Seniors Lodge		Grande Cache								X			
Grande Prairie Care Centre		Grande Prairie						X		X			
NAC Business & Industry Clinic	X	Grande Prairie	X										
Northern Addiction Centre	X	Grande Prairie	X										
Points West Living Grand Prairie		Grande Prairie						X		X			
Queen Elizabeth II Hospital	X	Grande Prairie				X	X	X					

North Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital (Acute Care)	Hospital (Subacute)	LTC (AUX, NH)	Palliative	SL	Cancer Centre	CACC	CACC (UCC, AACC)
Grande Prairie Cancer Centre	X	Grande Prairie	Co-located on same campus as Queen Elizabeth II Hospital								X		
The Gardens at Emerald Park		Grande Prairie								X			
Youth Detoxification Services	X	Grande Prairie	X										
Grimshaw/Berwyn and District Community Health Centre	X	Grimshaw				ED		X	X				
Action North Recovery Centre		High Level	X										
Northwest Health Centre	X	High Level				X		X					
High Prairie Health Complex	X	High Prairie				X							
J.B. Wood Continuing Care Centre	X	High Prairie						X					
Metis Indian Town Alcohol Association (MITAA Centre)		High Prairie	X										
Hinton Healthcare Centre	X	Hinton				X							
Hinton Community Cancer Centre	X	Hinton	Co-located on same campus as Hinton Community Cancer Centre								X		
Mountain View Centre		Hinton								X			
Hythe Continuing Care Centre	X	Hythe						X					
Jasper Alpine Summit Seniors Lodge		Jasper								X			
Seton - Jasper Healthcare Centre	X	Jasper				X							
Heimstaed Lodge		La Crete								X			
La Crete Continuing Care Centre	X	La Crete						X	X				
La Crete Health Centre	X	La Crete											X
William J. Cadzow - Lac La Biche Healthcare Centre	X	Lac La Biche				X		X					
Manning Community Health Centre	X	Manning				X		X					
Extendicare Mayerthorpe		Mayerthorpe						X					
Mayerthorpe Healthcare Centre	X	Mayerthorpe				X		X					
Pleasant View Lodge		Mayerthorpe								X			
Manoir du Lac		McLennan						X		X			
Sacred Heart Community Health Centre	X	McLennan				X							
Chateau Lac St. Anne		Onoway								X			
Peace River Community Health Centre	X	Peace River				X		X					
Peace River Community Cancer Centre	X	Peace River	Co-located on same campus as Peace River Comm. Health Centre								X		
Radway Continuing Care Centre	X	Radway						X					
Rainbow Lake Health Centre	X	Rainbow Lake										X	

North Zone

Facility Name	Operated by AHS	Location	Addiction	Comm MH	Psych	Hospital (Acute Care)	Hospital (Subacute)	LTC (AUX, NH)	Palliative	SL	Cancer Centre	CACC	CACC (UCC, AACC)
Redwater Healthcare Centre	X	Redwater				X		X					
Slave Lake Healthcare Centre	X	Slave Lake				X		X					
Vanderwell Lodge		Slave Lake								X			
George McDougall - Smoky Lake Healthcare Centre	X	Smoky Lake				X		X					
Smoky Lake Continuing Care Centre	X	Smoky Lake						X					
Central Peace Health Complex	X	Spirit River				X		X					
Extendicare St. Paul		St Paul						X					
St. Therese - St. Paul Healthcare Centre	X	St Paul				X		X					
St. Paul Abilities Network		St. Paul		X						X			
Swan Hills Healthcare Centre	X	Swan Hills				X							
Valleyview Health Centre	X	Valleyview				X		X					
Vilna Villa		Vilna								X			
Smithfield Lodge		Westlock								X			
Westlock Healthcare Centre	X	Westlock				X		X					
Spruceview Lodge		Whitecourt								X			
Whitecourt Healthcare Centre	X	Whitecourt				X							

Bed Numbers by Zone

Reported Beds Staffed and in Operation Summary as of March 31, 2013

ZONE	ADDICTION AND MENTAL HEALTH			ACUTE CARE	CONTINUING CARE - FACILITY LIVING			SUPPORTIVE LIVING				TOTAL CONTINUING CARE (LTC + SL)	TOTAL CONTINUING CARE INCLUDING PALLIATIVE	TOTAL BEDS
	ADDICTION	COMMUNITY MENTAL HEALTH	PSYCHIATRIC (STAND-ALONE FACILITY)	ACUTE CARE	SUB-ACUTE (NON ACUTE CARE FACILITY)	LONG TERM CARE SUBTOTAL (AUXILIARY + NURSING HOME)	PALLIATIVE (NON ACUTE CARE FACILITY)	LEVEL 3	LEVEL 4	LEVEL 4 DEMENTIA	SUPPORTIVE LIVING SUBTOTAL (SL 3 + SL 4 + SL4D)			
South Zone	53	0	0	654	24	885	20	310	933	407	1,650	2,535	2,555	3,286
Calgary Zone	274	336	153	2,691	280	5,082	95	226	732	312	1,270	6,352	6,447	10,181
Central Zone	67	31	330	1,098	4	2,352	10	407	556	186	1,149	3,501	3,511	5,041
Edmonton Zone	290	166	495	2,885	185	4,963	64	420	2,040	894	3,354	8,317	8,381	12,402
North Zone	126	6	0	902	18	1,272	13	189	270	97	556	1,828	1,841	2,893
AHS TOTAL	810	539	978	8,230	511	14,554	202	1,552	4,531	1,896	7,979	22,533	22,735	33,803

Reported Beds Staffed and in Operation Summary as of March 31, 2012

ZONE	ADDICTION AND MENTAL HEALTH			ACUTE CARE	CONTINUING CARE - FACILITY LIVING			SUPPORTIVE LIVING				TOTAL CONTINUING CARE (LTC + SL)	TOTAL CONTINUING CARE INCLUDING PALLIATIVE	TOTAL BEDS
	ADDICTION	COMMUNITY MENTAL HEALTH	PSYCHIATRIC (STAND-ALONE FACILITY)	ACUTE CARE	SUB-ACUTE (NON ACUTE CARE FACILITY)	LONG TERM CARE SUBTOTAL (AUXILIARY + NURSING HOME)	PALLIATIVE (NON ACUTE CARE FACILITY)	LEVEL 3	LEVEL 4	LEVEL 4 DEMENTIA	SUPPORTIVE LIVING SUBTOTAL (SL 3 + SL 4 + SL4D)			
South Zone	53	0	0	654	24	885	10	270	915	380	1,565	2,450	2,460	3,191
Calgary Zone	273	332	133	2,588	280	5,083	95	249	450	235	934	6,017	6,112	9,718
Central Zone	63	31	330	1,086	4	2,352	10	457	409	149	1,015	3,367	3,377	4,891
Edmonton Zone	287	153	455	2,899	199	4,963	64	441	1,921	771	3,133	8,096	8,160	12,153
North Zone	126	6	0	887	18	1,330	3	163	203	50	416	1,746	1,749	2,786
AHS TOTAL	802	522	918	8,114	525	14,613	182	1,580	3,898	1,585	7,063	21,676	21,858	32,739

Change from March 31, 2012 to March 31, 2013

ZONE	ADDICTION AND MENTAL HEALTH			ACUTE CARE	CONTINUING CARE - FACILITY LIVING			SUPPORTIVE LIVING				TOTAL CONTINUING CARE (LTC + SL)	TOTAL CONTINUING CARE INCLUDING PALLIATIVE	TOTAL BEDS
	ADDICTION	COMMUNITY MENTAL HEALTH	PSYCHIATRIC (STAND-ALONE FACILITY)	ACUTE CARE	SUB-ACUTE (NON ACUTE CARE FACILITY)	LONG TERM CARE SUBTOTAL (AUXILIARY + NURSING HOME)	PALLIATIVE (NON ACUTE CARE FACILITY)	LEVEL 3	LEVEL 4	LEVEL 4 DEMENTIA	SUPPORTIVE LIVING SUBTOTAL (SL 3 + SL 4 + SL4D)			
South Zone	0	0	0	0	0	0	10	40	18	27	85	85	95	95
Calgary Zone	1	4	20	103	0	-1	0	-23	282	77	336	335	335	463
Central Zone	4	0	0	12	0	0	0	-50	147	37	134	134	134	150
Edmonton Zone	3	13	40	-14	-14	0	0	-21	119	123	221	221	221	249
North Zone	0	0	0	15	0	-58	10	26	67	47	140	82	92	107
AHS TOTAL	8	17	60	116	(14)	(59)	20	(28)	633	311	916	857	877	1,064

Partner Foundations and Health Trusts

Foundations are important partners of AHS committed to serving their communities and we are grateful for their support. Raising over $200 million yearly, our partner Foundations make a tremendous impact. The shared commitment between AHS, Foundations, and their donors in the community translates into positive patient experiences.

ZONE	FOUNDATION
Provincial	Alberta Cancer Foundation
South Zone	Bassano & District Health Foundation
	Bow Island & District Health Foundation
	Brooks & District Health Foundation
	Cardston & District Health Foundation
	Chinook Regional Hospital Foundation
	Crowsnest Pass Health Foundation
	Fort Macleod & District Health Foundation
	Medicine Hat & District Health Foundation
	North County Health Foundation
	Oyen & District Health Care Foundation
	Taber & District Health Foundation
	Windy Slopes Health Foundation
Calgary Zone	Alberta Children's Hospital Foundation
	Calgary Health Trust
	Canmore and Area Health Care Foundation
	Claresholm and District Health Foundation
	High River District Health Care Foundation
	Rosebud Health Foundation
	Sheep River Health Trust
	Strathmore District Health Foundation
	Vulcan County Health & Wellness Foundation
	EMS Foundation (Calgary)
Central Zone	Consort Hospital Foundation
	Coronation Health Centre Foundation
	David Thompson Health Trust
	Daysland Hospital Foundation
	Drayton Valley Health Services Foundation
	Drumheller Area Health Foundation
	Lacombe Hospital and Care Centre Foundation
	Ponoka and District Health Foundation
	Provost and District Health Services Foundation

ZONE	FOUNDATION
Central Zone	Red Deer Regional Hospital Foundation
	Stettler Health Services Foundation
	Tofield & Area Health Services Foundation
	Viking Health Foundation
	Wainwright & District Community Foundation
	Wetaskiwin Health Foundation
Edmonton Zone	Mental Health Foundation
	Black Gold Health Foundation
	Capital Care Foundation
	Devon General Hospital Foundation
	Fort Saskatchewan Community Hospital Foundation
	Glenrose Rehabilitation Hospital Foundation
	Royal Alexandra Hospital Foundation
	Stollery Children's Hospital Foundation
	Strathcona Community Hospital Foundation
	Sturgeon Community Hospital Foundation
	Tri-Community Health and Wellness Foundation
	University Hospital Foundation
Central Zone	Beaverlodge Hospital Foundation
	Fairview Health Complex Foundation
	Grande Cache Hospital Foundation
	Grimshaw/Berwyn Hospital Foundation
	Hinton Health Care Foundation
	Hythe Nursing Home Foundation
	Jasper Health Care Foundation
	Northern Lights Regional Health Foundation
	Northwest Health Foundation
	Peace River and District Health Foundation
	Queen Elizabeth II Hospital Foundation
	Regional EMS Foundation
	St. Paul & District Hospital Foundation
	Valleyview Health Centre Foundation

ALBERTA HEALTH SERVICES
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